HOSPITAL Topics

GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES

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Setting Up A Tumor Registry
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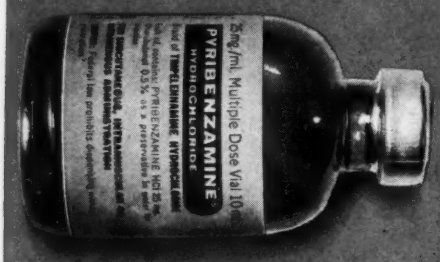
announcing



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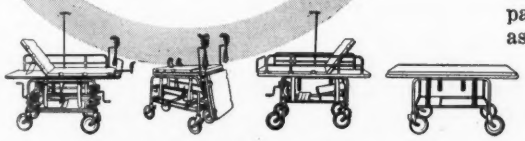

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HOSPITAL Topics

GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES

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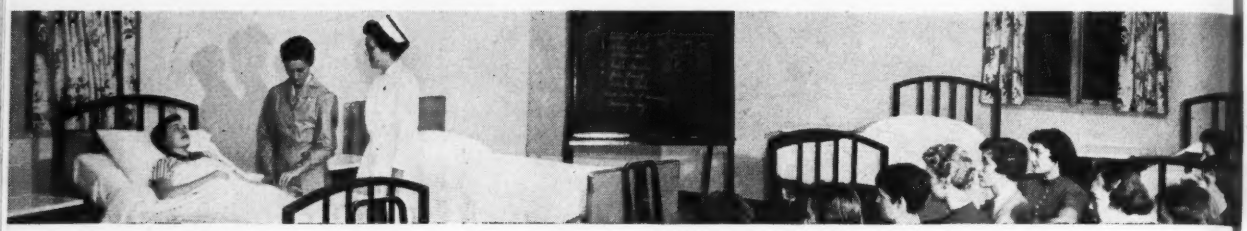

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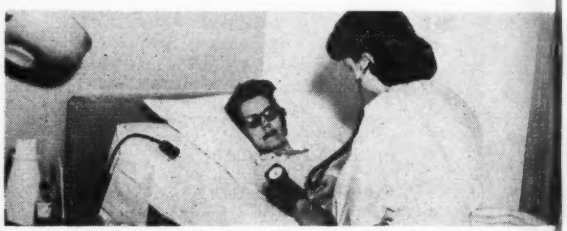

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PERSONALITY OF THE MONTH

Albert W. Snoke, M.D., who will become president of the American Hospital Association at the 58th annual convention in Chicago this month, has really gone all out for hospital organization work this year. He has also been president of the Connecticut Hospital Association.

Since 1946 he has been director, Grace-New Haven Community Hospital, New Haven, Conn., and professor of hospital administration at Yale University. Nearly every patient division in the older part of the hospital plant has been extensively refurnished and renovated during his administration. He was also chiefly responsible for the addition of a new 322-bed unit, in operation for three years now, which increased bed capacity to 658.

Dr. Snoke, born in Fort Steilacom, Wash., was graduated from the University of Washington and obtained his M.D. degree from the Stanford University Medical School in 1933. He served his internship at the Stanford University Hospitals, and also had one year as assistant resident in medicine and pathology, and two years as assistant resident and resident in pediatrics.

From Stanford he went to Strong Memorial Hospital, Rochester, N. Y., as associate resident in pediatrics. The hospital's director, Basil C. MacLean, M.D., now Commissioner of Hospitals in New York City, offered him an assistant directorship in 1937.

While at Strong Memorial, Dr. Snoke helped pioneer one of the early regional plans for integrating community hospital facilities.

He is a fellow of the American College of Hospital Administrators and a member of the American Association of Hospital Consultants, and has served on the Federal Hospital Council. He has been chairman of AHA councils on hospital planning and plant operation, prepayment and hospital reimbursement, and professional practice.

He is an AHA representative on the liaison committee between the AHA and AMA, and is a diplomate of the American Board of Pediatrics and the American Board of Preventive Medicine and Public Health.

Dr. Snoke was married in 1934 to Parnie Hamilton Storey, who herself was a physician. His father, father-in-law, and sister-in-law have been physicians. The Snokes have three sons — Albert Thomas, 17; John Arthur, 15, and Michael David, 11.

Camping and hiking are among Dr. Snoke's favorite hobbies.

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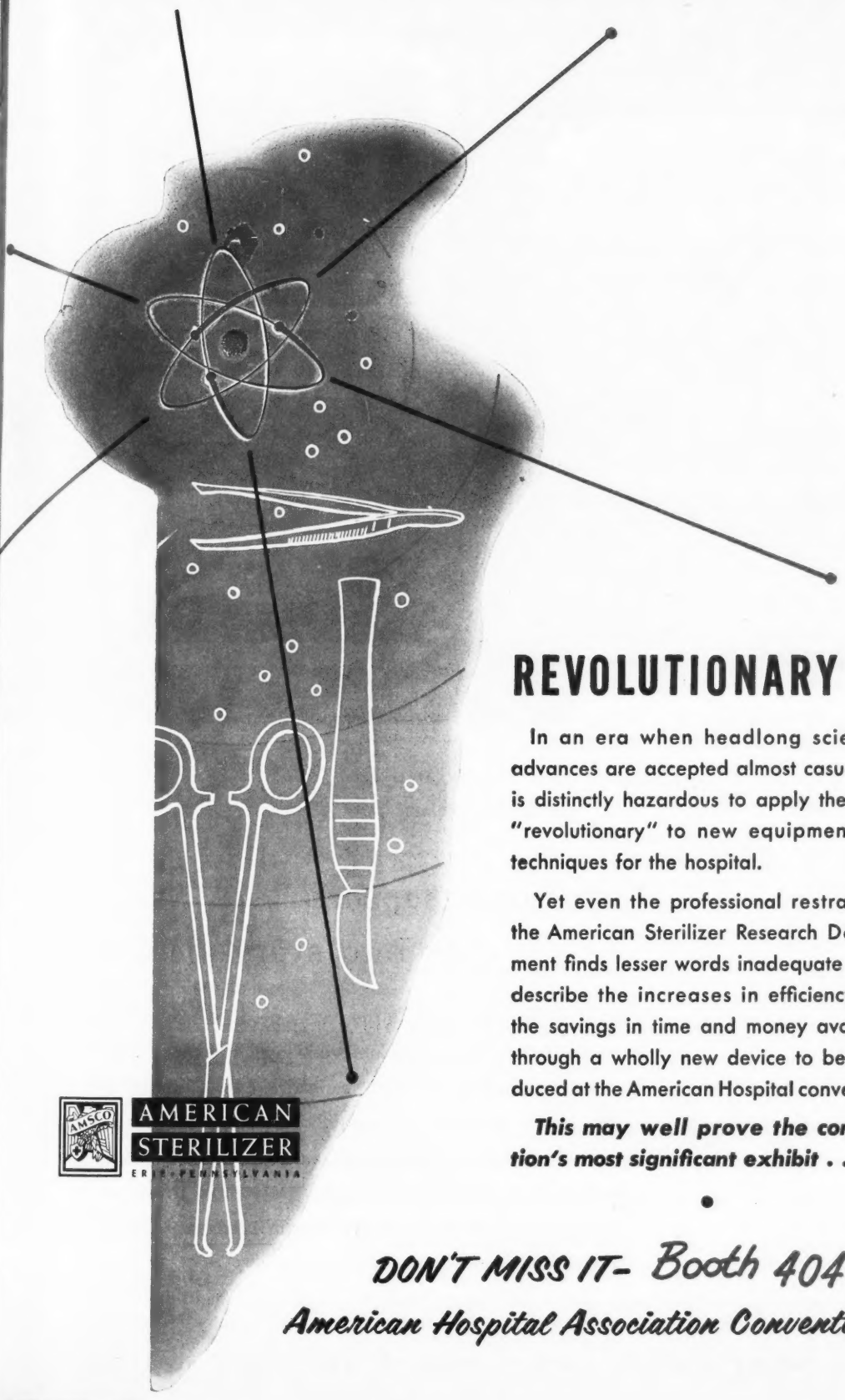

REVOLUTIONARY ?

In an era when headlong scientific advances are accepted almost casually, it is distinctly hazardous to apply the word "revolutionary" to new equipment and techniques for the hospital.

Yet even the professional restraint of the American Sterilizer Research Department finds lesser words inadequate . . . to describe the increases in efficiency and the savings in time and money available through a wholly new device to be introduced at the American Hospital convention.

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HOSPITAL Topics
The News Magazine for the Hospital Staff

SEPTEMBER 1956
VOL. 34, NO. 9

Scanning the News

New IQ Test For the Blind

A new IQ test has been devised for blind persons by two researchers at the Illinois Institute of Technology.

S. B. Watson, M.D., and Harriett Shurrager, M.D., say their new test was planned to improve measuring vocational capabilities of the blind.

The verbal phase of the standard IQ test was combined with a performance test seeking to measure manual dexterity and perceptual ability without the usual clues.

Completely blind persons do better in the test than sighted persons or those with partial vision, according to Dr. Watson.

Live Cancer Cell Injections Produce Local Reaction

Convicts voluntarily injected with live cancer cells have experienced a marked local reaction, says Chester M. Southam, M.D., who, with another staff member of the Sloan-Kettering Institute for Cancer Research, is conducting a study of 14 prisoners at the Ohio State Penitentiary.

Purpose was to study the body's resistance to cancerous cells, but not to try to transmit the disease.

"These normal men have shown a more marked defense reaction than have people known to have cancer, who have been similarly injected," Dr. Southam said.

New Hormone is Synthesized At Cornell University

A second hormone from the pituitary gland, vasopressin, has been synthesized at Cornell University Medical College, New York City, reports the *Journal of the American Chemical Society*.

Vasopressin acts to raise blood pressure and as an anti-diuretic.

Synthesis of oxytocin was achieved in 1955 by a group headed by Prof. Vincent du Vigneaud, who was also in charge of the second project.

The synthesis of both hormones, composed of amino acids, permits new chemical technics for producing more complicated hormones artificially, such as insulin and ACTH.

Synthetic vasopressin may be useful in the treatment of diabetes insipidus and may also eliminate allergic reactions sometimes produced by contaminants of natural pituitary extracts, the scientists say.

A new station wagon has been presented to the East Orange (N. J.) Hospital by the hospital's Men's League, which sponsored a contest to raise funds to replace station wagon which had been in the hospital's service since World War II. Grand prize was an all-expense trip to Bermuda for two. The car was presented to Edgar C. Hayhow, M.D. (l.), hospital director, by James G. Bruce, League president. Looking on are: LeRoy Griggs, president, Griggs Motor Sales, Inc., and Russell Fairhurst, second vice-president, Fidelity Union Trust Co.

Men Suicides Outnumber Women, 3-1

The male-female suicide ratio is about three men to one woman, figures published by a United Nations World Health Organization survey show.

The critical age for men is in the over-70 group; for women, between ages 50 and 60.

This ratio varies from more than four to one in Norway to less than two to one in Japan, the survey reveals. Japan, Denmark, Austria, and Switzerland have the highest ratio; Ireland, Northern Ireland, Chile, Scotland, and Spain the lowest.

Coronaries in Women On Increase

Coronary heart disease, once almost exclusively confined to males, since 1940 has attacked women as often as men, report two doctors in the *American Journal of Pathology*.

Cited as possible influences were increased smoking by women, and the increased number of women in the older age brackets.

New Current Developed For Electro-physiology

Batronics, a new type of current for use in the field of electro-physiology has been developed by Batrow Laboratories Inc.

Batronics consists of damped oscillation, so highly damped that the first half pulse is predominant—duration is in micro-seconds.

It is applied to the body through a glass electrode filled with inert gas under negative pressure.

This method of driving the diaphram with electrical pulses was developed in conjunction with a team of doctors including Frank Gray, M.D., Jr., New Haven, Conn. and associates.

Radioisotope Removed From Liquid Waste

Radioactive cesium (Cs 137) removed from liquid waste at the General Electric Co., Hartford (Conn.) plant can be used for medical and industrial uses. Its long half-life makes it potentially valuable in medical therapy, inspection of opaque materials and food sterilization, since it gives off x-ray type radiation. The long half-life makes it advantageous because it minimizes the need for recalibration and replacement.

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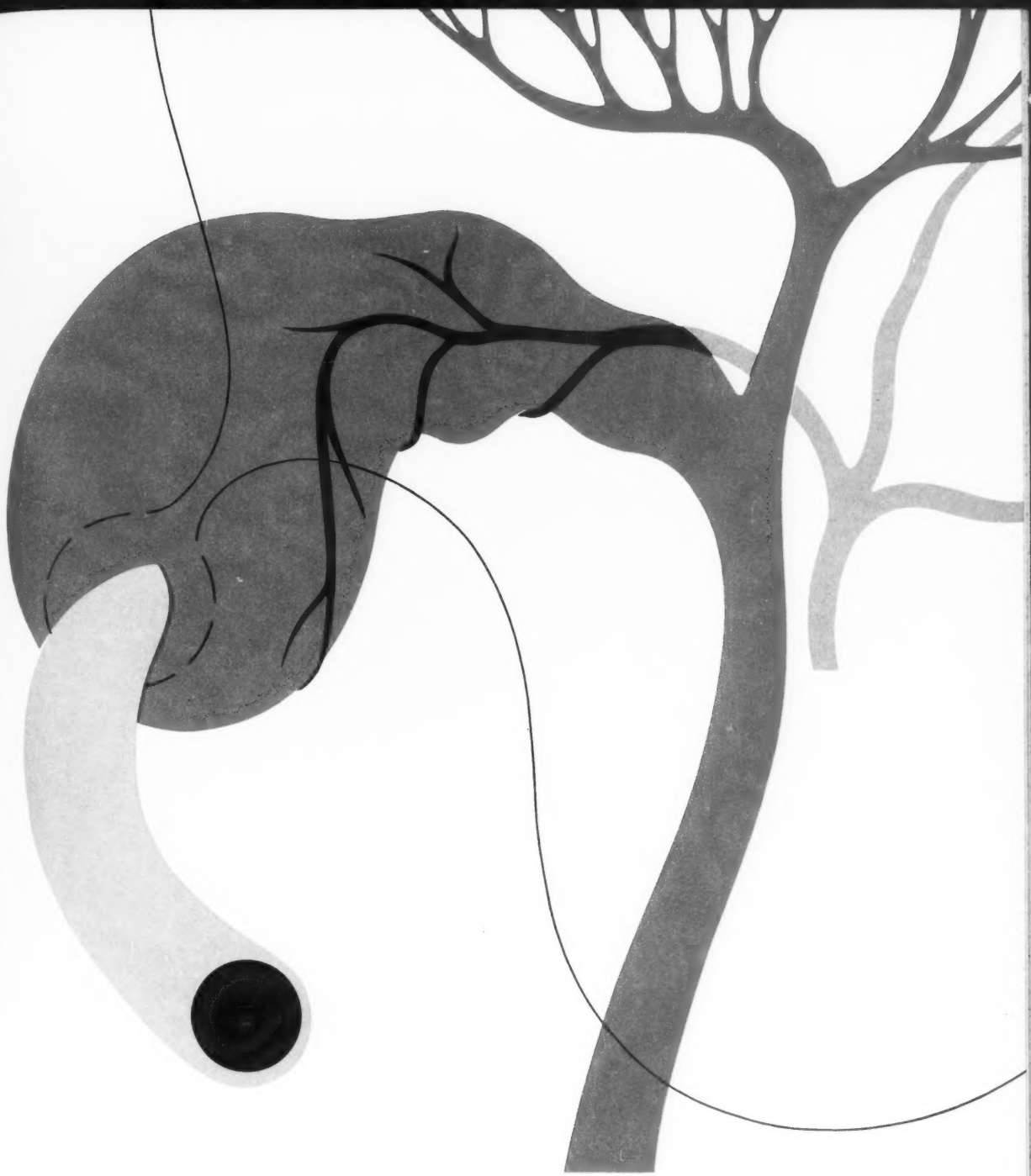

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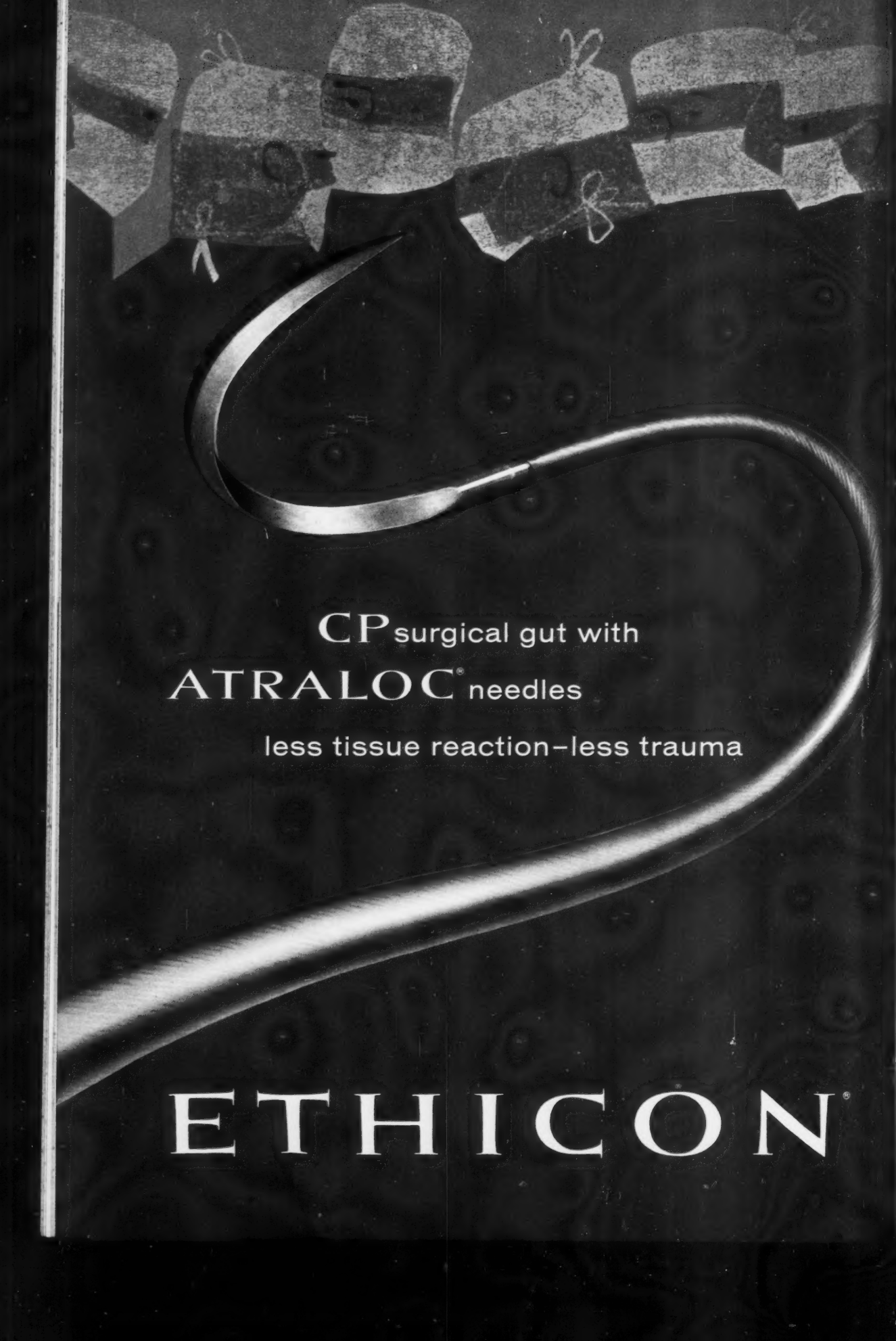
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News Briefs at Press Time

LOOK FOR SERIES ON PROBLEMS OF HOSPITAL NURSING SCHOOLS

Many hospitals have closed their nursing schools because they were losing money. Administrator Warren Von Ehren tells in this issue (see page 23) why the Bellin Memorial Hospital, Green Bay, Wis., decided to reopen its school-- and how successful the educational program has been.

Because of the great concern indicated in the field about hospital schools, TOPICS next month will begin a series about their problems.

The first article will summarize the problems. Subsequent articles will discuss recruitment of students and the related problem of physical facilities.

RADIOLOGISTS CHARGE PITTSBURGH BLUE CROSS INFRINGING ON BLUE SHIELD

Western Pennsylvania physicians are up in arms about what they charge is an attempt by Pittsburgh Blue Cross to get into medical care coverage through inpatient and outpatient diagnostic medical service.

An "additional benefits" provision of Pittsburgh Blue Cross, announced several months ago, provided coverage for such cases as outpatient services for surgery; admissions for certain types of dental care; admissions primarily for treatment of mental and nervous disorders; outpatient admissions for radiation therapy, with a $70 annual allowance; and a cooperative payment arrangement for inpatient and outpatient visits to the hospital, primarily for diagnostic study. Under this cooperative payment plan, the subscriber would pay $5 a visit.

As a result of opposition by Allegheny County Medical Society, which charged that provision of diagnostic services by hospitals constitutes the corporate practice of medicine, Pennsylvania Blue Shield coverage has been expanded to include diagnostic x-ray services in or out of a hospital, for subscribers in certain groups in the area affected by the Blue Cross announcement.

The Blue Shield coverage will be provided in conjunction with similar benefits offered by Blue Cross and will be available on the basis that the subscriber must purchase both coverages.

Among examinations not included are those in connection with pregnancy, routine physical examinations or checkups, routine hospital admission procedures, or those for which payments are claimed by hospitals or any other institutions or which are covered to any extent under a Hospital Service contract.

FEDERAL FUNDS AVAILABLE FOR EDUCATING NURSING SUPERVISORS

A program of traineeships for preparing professional nurses to teach or to become administrators or supervisors is established under Public Law 911, passed by Congress just before adjournment.

The act also extends Hill-Burton until June 30, 1959.

Congress has appropriated $2,000,000 for the nurse traineeship program for the fiscal year ending June 30, 1957. The traineeships will be available for fall 1956 enrollment.

A TOPICS 'THANK-YOU'

This is TOPICS' biggest issue so far. Our sincere thanks to you, our readers, and to our advertisers for your contributions to our growth. We are working hard on plans to make the issues ahead better than ever. Your suggestions for improvement will be welcomed at any time.

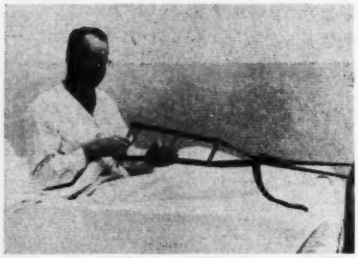
When you're at the AHA, stop and see us at booths 952 and 149. If you can't get away to the meeting this year, look for TOPICS' concise report of it in the October issue.

Gordon M. Marshall

Look for the TOPICS staff at the AHA—

First row (seated l. to r.): Gordon M. Marshall; Virginia Page; Betty Miller; Marie Jett; Lois Smith; Elsie Dorsch; Florence Freundt. Second row (l. to r.): Gunhild Moberg; Barbara Work; Mary Daley; Nina Stein; David Kott; Muriel Dow.

For Patient Protection



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Calendar of Meetings

SEPTEMBER

3- 5 American Association of Blood Banks, Somerset Hotel, Boston, Mass.

4-14 O. R. Workshop, University of Minnesota Center for Continuation Study, Minneapolis.

4-14 American College of Hospital Administrators 24th Institute, International House, University of Chicago

6- 7 Northern California chapter, American Association Hospital Accountants, Palace Hotel, San Francisco.

9-13 International College of Surgeons, Palmer House, Chicago

10-14 American Congress of Physical Medicine and Rehabilitation, Ambassador Hotel, Atlantic City, N. J.

12-13 AWH Workshop on Admitting Practices, Hotel Benson, Portland

17-20 American Hospital Association, Palmer House, Chicago

26-28 Michigan State Medical Soc'y, Sheraton-Cadillac Hotel, Detroit, Mich.

28-29 American Medical Writers' Association, Hotel Morrison, Chicago

OCTOBER

1- 4 AHA Evening & Night Nursing Institute, Adolphus Hotel, Dallas

1- 5 American Assn. Medical Record Librarians, Shoreham Hotel, Washington, D. C.

8- 9 South Dakota Hospital Association Sheraton-Johnson Hotel, Rapid City, S. D.

8- 9 Oregon Association of Hospitals Hotel Senator, Salem

8-11 American Academy of Pediatrics Hotel Statler, New York

8-12 American Society of Anesthesiologists, Inc., Kansas City Auditorium

8-12 American College of Surgeons, Clinical Congress, Fairmont Hotel, San Francisco

9-12 American Dietetic Association Auditorium, Milwaukee, Wis.

9-13 American Society of Clinical Pathologists, Drake Hotel, Chicago

10-11 Washington State Hospital Association, Chinook Hotel, Yakima, Wash.

10-12 Montana Hospital Association Florence Hotel, Missoula

15-19 AHA Medical Record Library Personnel Institute, Hotel Jefferson, Richmond, Va.

16-18 Associated Hospitals of Alberta MacDonald Hotel, Edmonton

17-18 Vermont Hospital Association Pico Peak, Long Trail Lodge, Rutland

17-19 American Association of Hospital Accountants, Florida chapter, Institute on Accounting, Daytona Plaza Hotel, Daytona Beach, Fla.

18-19 Mississippi Hospital Association, Hotel Edwards, Jackson, Miss.

24-25 Indiana Hospital Association Student Union Building, University of Indiana Medical Center

24-26 California Hospital Association St. Claire Hotel, San Jose

25-26 Nebraska Hospital Association Hotel Fontenelle, Omaha

27-28 American College of Osteopathic Hospital Administrators, Sheraton-Cadillac Hotel, Detroit, Mich.

28-31 Annual Convention, National Society for Crippled Children and Adults Hotel Statler, Washington, D. C.

28-31 American Osteopathic Hospital Association, Sheraton-Cadillac, Detroit, Mich.

NOVEMBER

5- 7 American College Obstetrics-Gynecology, Palmer House, Chicago

5- 9 AHA Nursing Service Administration Institute, Sheraton-Gibson Hotel, Cincinnati

6- 7 Colorado Hospital Association Broadmoor Hotel, Colorado Springs

8 IHA Methods Improvement Institute Bradley University, Peoria, Ill.

8- 9 Oklahoma Hospital Association Skirvin Hotel, Oklahoma City

9 Minnesota Hospital Association Hotel St. Paul, St. Paul, Minn.

11-14 Assoc. Military Surgeons of the U. S. Statler Hotel, Washington, D. C.

12-16 American Public Health Association Convention Hall, Atlantic City, N. J.

15-16 Kansas Hospital Association Baker Hotel, Hutchinson

15-17 Arizona Hospital Association Westward Ho Hotel, Phoenix

15-20 American Surgical Trade Association 24th Regiment Armory, New York

16-17 Virginia Hospital Association Hotel Roanoke, Roanoke, Va.

27-30 American Medical Association, Clinical Meeting, Civic Auditorium, Seattle

DECEMBER

6- 7 Illinois Hospital Association Hotel Abraham Lincoln, Springfield, Ill.

8-13 American Academy of Dermatology and Syphilology Palmer House, Chicago

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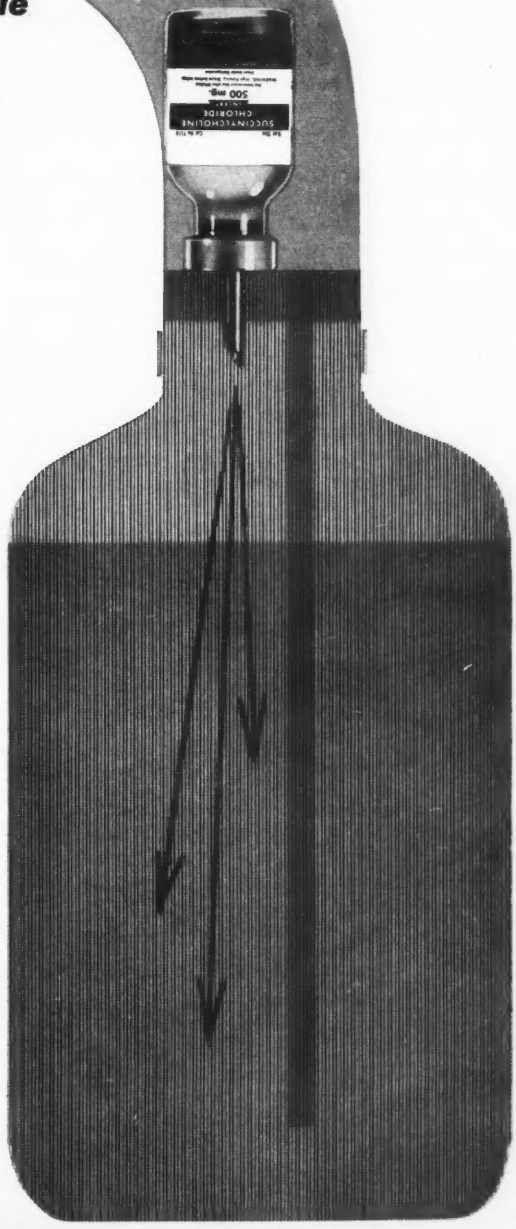

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Chicago Hospitals Welcome AHA

Here is the latest news on hospitals in Chicago, the AHA convention city—gathered by the TOPICS staff. Many of these hospitals will welcome visitors during the AHA meeting, September 17-20. Requests for advance notice and limitations on hours for visits are included in this special convention feature.

Alexian Brothers Hospital, 1200 Belden Ave. Administrator: Brother Constantine, R.N. 250 beds. Open house for AHA visitors September 18-19, 10-5 p.m. The new central service unit established at this hospital is well worth viewing. Particular attention has been given to work flow and simplification and standardization of procedures.

American Hospital of Chicago, 850 W. Irving Park. President: Max Thorek, M.D. 185 beds, 20 bassinets. Residency training program attracts students from all over the world. Board members have worked out a system whereby, without any endowment, the hospital annually gives $200,000-$230,000 of free service to those unable to pay.

Facilities are being expanded with money from the Ford grant.

Augustana Hospital, 411 W. Dickens Ave. Superintendent: E. E. Erickson. 320 beds, 36 bassinets. AHA visitors welcome, 9-4. Please come to the information desk on arrival. Auxiliary celebrates 50th anniversary this year. X-ray department has recently been expanded.

Belmont Community Hospital, 4058 Melrose St. Administrator: J. W. McCracken. 110 beds, 25 bassinets. An expansion program is contemplated, which is hoped to be under way by October of this year. It is expected that the addition will include a new x-ray department, dining-room, three operating rooms, a new obstetrical department, and approximately 60 additional beds. It is also intended to remodel the present first floor which will include lobby, business offices, and laboratory.

Bethany Methodist Hospital, 5025 N. Paulina St. Administrator: Bertil W. Selin. 100 beds. AHA visitors welcome. This hospital is planning an addition to the present hospital which will increase the bed capacity by 65, primarily to accommodate the chronically ill patient.

Bethany Sanitarium and Hospital, 3420 W. Van Buren St. Administrator: John C. Eller. 70 beds, 21 bassinets. AHA visitors welcome. This hospital has recently compiled its own disaster program book.

Burrows Hospital, 669 Irving Park, 25 beds, Surgeon-in-Chief: Samuel J. Burrows, M.D. AHA visitors welcome, 9-5.

Catherine Booth Hospital & Clinics, 426 W. Wisconsin St. Administrator: W. P. Annis. 108 beds. The first hospital in this area to provide geriatric care on a hospital basis. AHA visitors welcome.

Chicago Clinic of Physical Medicine. 6970 N. Clark St. Medical Director: Milton Schmitt, M.D. 60 beds. This hospital provides facilities for carrying out an intensive treatment program for patients suffering from physical disability. Clinical and basic research provides teaching program for the Stritch School of Medicine at Loyola University.

Chicago Eye, Ear, Nose and Throat Hospital, 231 W. Washington St. Medical Director: Oscar B. Nugent, M.D. 40 beds. Large, air-conditioned OPD processes 100 outpatients daily. AHA visitors are welcome.

Chicago State Hospital, 6500 Irving Park Rd. Superintendent: Kalman Gyarfas, M.D. 4,921 beds.

Chicago Wesley Memorial Hospital, 250 W. Superior St. Superintendent: Ralph M. Hueston. 617 beds, 45 bassinets. Excavation now in process and foundation being laid for the new addition to the north side of the present hospital building. It will be a five-story U-shaped building which can be expanded to 16 stories. This new unit will increase the bed capacity to 700. Please contact public relations department for appointment to visit.

Children's Memorial Hospital, 707 Fullerton Ave. Administrator: Delbert L. Price. This 74-year-old hospital, with 11 buildings and a capacity of 225 beds, is undergoing extensive remodeling and renovating. A new surgical suite, biopsy laboratory, recovery room, and a surgical patient wing have been in service for more than a year.

Visitors will be welcome from 9 a.m. - 5 p.m. during the AHA convention. At 2:15 p.m. September 20, auxiliary members will be taken on conducted tours. They will see hospital wards and rooms, in which more than 6,000 hospitalized children are cared for each year, and the clinic building, in which more than 12,000 ambulatory patients are treated in some 63,000 visits.

Columbus Hospital, 2520 N. Lakeview Ave. Administrator: Mother Valentina. 350 beds, 40 bassinets. A six-story addition to the Columbus Hospital, now being constructed, will house a tumor treatment center, isotope laboratories, a heart and lung function laboratory, and other research facilities. This building will be known as the Mother Antonietta Della Casa Research Memorial.

Cook County Hospital, 1825 W. Harrison St. Warden: Fred A. Hertwig. Medical Director: George C. Blaha, M.D. 3,400 beds. AHA visitors welcome. Please make advance arrangements. This hospital, founded in 1847, is the largest of its kind in the world, caring for the medically indigent. A total of 84,980 patients were admitted in 1955. Some of the more recently completed projects in the hospital's long-range program of rehabilitation and expansion include the radiation center, which has a cobalt unit; the central diagnostic x-ray department, and the modernized central supply department and solutions laboratory, blood preservation laboratory, central kitchen.

Edgewater Hospital, 5700 N. Ashland Ave. Administrator: Frank Brown. 288 beds, 48 bassinets. This hospital has an air-conditioning system throughout the hospital —also a pneumatic tube system. Remote-control TV in every room. AHA visitors welcome, 1:30-4:30 p.m.

Englewood Hospital 6001 S. Green St. Administrator: Wendell H. Carlson. 154 beds, 30 bassinets. Project is under way, utilizing Ford Foundation grant, to remodel and equip x-ray department ($72,000).

Evangelical Hospital, 5421 S. Morgan St. Administrator: Joseph A. George, D.D. 195 beds—38 bassinets. Property in Oaklawn (20 acres) was recently purchased for an

extension of this general hospital, which is also in the midst of reorganization for a campaign for $750,000.

Evanston Hospital, 2650 Ridge Ave., Evanston. Administrator: A. B. Cook. 325 Beds, 50 bassinets. AHA visitors welcome. This hospital plans to start construction this year on a new five-story wing, costing well over $4,000,000, which will increase the bed capacity to 425 and bassinets to 92.

Sidney R. Forkosh Memorial Hospital (formerly Manor Hospital), 2544 W. Montrose Ave. Administrator: Mose Ellis. 60 beds. AHA visitors welcome. A building program being considered, to increase this hospital's bed capacity by 40, will include a new ancillary service department.

Frank Cuneo Hospital, 4420 N. Clarendon Ave. Superintendent: Mother Onorina. 70 beds, 40 bassinets. AHA visitors welcome.

Franklin Boulevard Community Hospital, 3240 W. Franklin Blvd. Administrator: P. A. DeMoon. 72 beds. AHA visitors welcome. This hospital has a new physical medicine department, and the new isotope laboratory is nearing completion. It hopes to break ground by June for a new building, to increase the bed capacity by 40 and to include a large OPD.

Garfield Park Community, 3813 W. Washington Blvd., Administrator: J. R. Garwin. 150 beds, 34 bassinets.

Grant Hospital, 551 Grant Pl. Executive Director: Norman D. Bailey. 240 beds, 46 bassinets. A pioneer hospital in the establishment of the medical audit (first in Chicago, third in the country), this hospital is also proud of being the new premature station serving the north areas of Chicago. AHA visitors welcome.

Henrotin, 939 N. LaSalle St., Administrator: Henrietta Drager, R.N. 100 beds, 25 bassinets.

Holy Cross Hospital, 2700 W. 69th St. Administrator: Sister M. Adeline, R.N. 145 beds, 36 bassinets.

Hospital of St. Anthony de Padua, 2875 W. 19th St. Administrator: Sr. Maristella. 250 beds, 35 bassinets. A.H.A. visitors welcome.

Ida Mae Scott Hospital, 5027 S. Prairie Ave. Medical Director: James M. Scott, M.D. 16 beds. AHA visitors welcome.

Illinois Central Hospital, 5800 Stony Island Ave. Administrator: J. F. Vanerio. 300 beds, 26 bassinets. AHA visitors are welcome.
Modern general hospital, established primarily to serve employees of the Illinois Central Railroad Co. A completely equipped OPD handles 32,000 patients per year.

Illinois E&E Infirmary, 904 W. Adams St. Superintendent: L. R. Gerber, 130 beds. Jointly operated by the Department of Welfare and Illinois University School of Medicine. Between 40 and 50 physicians, without pay, staff this hospital, which is approved for three-year EENT residency and is the largest tax-supported institution of its kind in the world. Clinic visits last year: 92,000. AHA visitors welcome.

Illinois Masonic Hospital, 836 Wellington St. Superintendent: William H. Tenny. 375 beds, 40 bassinets. Buildings now being razed to make room for new $2,000,000 addition—consisting of eight floors, two subbasements. Buildings will contain a clinic, dispensary, clinical laboratory, cobalt bomb, new O.B. department, an additional O.R., and interns' quarters. Construction will start in October.

AHA visitors welcome.

Jackson Park Hospital, 7531 Stony Island Ave. Administrator: L. W. Hilton. 146 beds, 20 bassinets. AHA visitors welcome. When this was written (mid-August), the hospital was averaging polio vaccine injections at the rate of 200 free a day.

Kenmore House Hospital, 5517 Kenmore Ave. Administrator: Daniel Halpern. 100 beds. AHA visitors welcome. A hospital that specializes in the aged and chronically ill patient.

Kenner's Charitable Hospital, 3150 Lake Shore Dr. Director: William H. Kenner, M.D. 65 beds.

La Rabida Jackson Park Sanitarium, E. 65th and S. Shore Dr. Business Administrator: Georgianna Richards. 92 beds. AHA visitors welcome. Recent opening of an adolescent ward increases the bed capacity of this hospital to 92. A home service program provides follow-up care for about 900 children who have had heart disease or rheumatic fever.

Lewis Memorial Maternity Hospital, 3001 S. Michigan Ave. Administrator: Sister Marguerita de Montmartre. 124 beds, 68 bassinets. Board of Health restricts visitors; sorry.

A maternity and gynecology hospital affiliated with Loyola. This hospital also has a prenatal, postnatal, and gynecological clinic and social service department connected with Loyola University of Chicago.

Loretto Hospital, 645 Central St. Administrator: Sr. Mary Dorothea. 160 beds, 33 bassinets. Currently establishing a recovery room (seven beds, possibly expanding to 12, with piped-in oxygen, suction apparatus, Stryker beds, OR-type bed in the emergency. AHA visitors welcome from 11 a.m.-4 p.m.

Louis A. Weiss Memorial Hospital, 4646 Marine Dr. Executive Director: Mortimer W. Zimmerman. 111 beds. AHA visitors welcome.

(Continued on next page)

The Veterans Administration Research Hospital, on the near north side in the Northwestern University Medical Center, is one of the hospitals on the tour list for auxiliary members.

Lutheran Deaconess Hospital, 1138 N. Leavitt St. Superintendent: V. W. Nelson. 186 beds, 40 bassinets. This nonprofit institution, owned and controlled by the Evangelical Lutheran Church of America, will celebrate its 60th anniversary next May.

Ground is expected to be broken for a 200-bed general hospital, in a northwestern area of greater Chicago, next year.

AHA visitors welcome.

Mark Howard Hospital, 4938 S. Drexel Blvd. Executive Director: J. Marvin Levinson. 104 private rooms. The first nonsectarian, privately owned, accredited chronic hospital in Chicago. Principle-medical procedure for the aged and chronically ill.

Martha Washington Hospital, 2318 Irving Park Rd. Administrator: Clare Mendes, R.N. 65 beds. AHA visitors welcome. A new building which will add 65 beds more to the Washingtonian Home, a part of this hospital, will be ready in the fall of 1957.

Mercy Hospital, 2537 Prairie Ave. Administrator: Sister Loretto, R.N. 365 beds, 40 bassinets. The first and oldest hospital in the Chicago area — established in 1851 — Mercy recently installed a new coffee shop and doctors' lounge. The medical record office is being revamped, and plans are being considered for relocating the hospital in Skokie.

Michael Reese Hospital, 2839 S. Ellis Ave. Medical Director: Morris H. Kreeger, M.D. 726 beds, 104 bassinets. Construction, at a cost of $810,000, has started on the Friend Memorial Pavilion — a 36-bed air-conditioned unit for convalescent patients. All rooms will overlook a park, which is being landscaped.

AHA visitors welcome — 1.30 - 4.30 p.m.

Mother Cabrini Memorial, 1200 W. Cabrini St. Superintendent: Rev. Mother M. Theresa, R.N. 150 beds, 30 bassinets.

Mt. Sinai Hospital. 2750 W. 15th Pl. Director: Stephen Manheimer, M.D. 373 beds, 35 bassinets. This hospital's bed capacity has grown from 60 to 408 since it was founded in 1919. It is sixth in size among the voluntary hospitals of Chicago. It affords educational facilities to medical students through its affiliation with the Chicago Medical School.

Municipal Contagious Diseases Hospital, 3026 S. California Ave. Superintendent: A. Borcher. Medical Superintendent: Harold W. Sties, M.D. 188 beds.

Norwegian-American, 1044 N. Francisco Ave. Superintendent: A. K. Besley. 173 beds, 35 bassinets.

Oak Park Hospital, 525 Wisconsin Ave., Oak Park. Administrator: Mother Oswald. 240 beds, 54 bassinets. AHA visitors welcome. The hospital has recently been remodeled. A new doctor's library and solariums on each floor have been added.

Passavant Memorial Hospital, 303 E. Superior St., Evanston. Director: John N. Hatfield. 263 beds, 35 bassinets. AHA visitors welcome. Ground was broken in August for a new $3,800,000 nine-story addition which will add 55 more beds. The new building will include: completely new surgical unit, clinical laboratories, x-ray department, unit for study of metabolism, physiotherapy department, conference room, lecture auditorium, dining room and kitchen. Other equipment includes two automatic hi-speed elevators, pneumatic tube system, audio-visual nurses call system.

Pinel Sanitarium, 741 Diversey Pkwy. Medical Director: Alex S. Herschfield, M.D. 50 beds. AHA visitors welcome. This hospital is going through an extensive rehabilitation and reconstruction of its interior — including advanced recreational and occupational therapy, x-ray, and expansion of its laboratory.

Presbyterian Home Hospital, 3200 Grant St., Evanston. Superintendent: Irene C. Anderson. 187 beds. Visitors welcome, 2-4 p.m. Please make arrangements for scheduled tours in advance.

This hospital is primarily for the geriatric and chronically ill patient. A few convalescent patients are cared for also.

Presbyterian Hospital, 1753 W. Congress St. Director: Karl S. Klicka, M.D. 432 beds, 45 bassinets. Plans for a 900-bed hospital, new type diagnostic clinic and other medical buildings, were outlined in late June. The first step in expanding services and facilities is a $7,000,000 fund-raising campaign set to begin in September. Immediate plans include: A hospital pavilion of 13 floors, which has been under construction for the past few months; rehabilitation of the present Presbyterian Hospital; expansion of the school of nursing, and construction of a new kitchen and employee cafeteria. Enlargement of the laundry has already been completed. Other long-range plans will be effective by 1960. The physical consolidation of Presbyterian and St. Luke's will take place at the completion of the 13-floor pavilion.

Provident Hospital, 426 E. 51st St. Executive Director: Clyde L. Reynolds. 205 beds. This hospital derives its financial support and public relations direction from its four women's auxiliaries — the Women's Auxiliary Board, Mabel Washington Guild, Junior Service League, and Volunteer Service Guild. All work independently to raise $25,000 each year.

AHA visitors welcome. They are requested to contact nursing service for a conducted tour.

Ravenswood Hospital, 1931 Wilson Ave. Superintendent: George Swanson. 207 beds, 52 bassinets. No visitors, please.

Building program is in progress to increase bed capacity. Fund-raising campaign seeks $250,000, counting Ford grant.

Resurrection Hospital, 7435 W. Talbot Ave. Administrator: Sistor Gregory, R.N. 186 beds, 44 bassinets.

Roosevelt Memorial Hospital, 716 Wellington Ave. Superintendent: Ruby Jones. 46 beds. AHA visitors welcome.

Roseland Community, 45 W. 111th St. Administrator: Joseph M. Cooke. 101 beds, 24 bassinets.

St. Anne's Hospital, 4950 Thomas St. Administrative Sister: Sr. M. Almunda, P.H.J.C. 402 beds, 80 bassinets.

This hospital is best known as being the "largest private maternity hospital in Chicago." Total deliveries for 1955 were 3,834. St. Anne's nursing school, with a student body of 120, was one of the first in Chicago to become fully accredited. AHA visitors welcome.

St. Bernard's Hospital, 6337 Harvard Ave. Administrator: Sister St. Joseph, R.N. 189 beds, 42 bassinets.

St. Elizabeth's Hospital, 1431 N. Claremont Ave. Administrator: Sister M. Joann, R.N. 270 beds, 50 bassinets. AHA visitors are welcome. This general hospital takes pride in its surgical suite, consisting of six major operating rooms and four minor operating rooms.

St. Francis Hospital, 355 Ridge Ave., Evanston. Administrator: Sister M. Stephania. 383 beds, 62 bassinets. In addition to a large orthopedic and pediatric service and an active OPD, St. Francis Hospital has a children's center devoted to oral and reconstructive surgery, with special emphasis on cleft palate rehabilitation. In the two years since the center opened, 1904 patients have been treated 25 percent of whom were adults. One of the few such hospital centers not connected with any university,

Program in Brief

Theme: "Planning for the Future"

Monday, September 17

9:30 a.m. — House of Delegates. Unveiling of portrait of the late Arthur C. Bachmeyer, M.D., by Charles F. Wilinsky, M.D.

Formal opening of technical exhibits.

2:15-4:15 p.m. — General session — "Planning for the Future"

"What Are the Needs?" — Theodore G. Klumpp, M.D., New York City, Chairman, Hoover Commission's Task Force on Medical Services, and Jack R. Ewalt, M.D., Boston, Director, Joint Commission on Mental Illness and Health

"What Are the Resources?" — Lowell T. Coggeshall, M.D., Special Assistant for Health and Medical Affairs to the Secretary of Health, Education, and Welfare, Washington, D.C., and George Bugbee, president, Health Information Foundation, New York City

6-9 p.m. — President's reception and tea dance

Tuesday, September 18

9:30-11:30 a.m. — Round-table sessions

Accounting — "Accounting, General Orientation for Small Hospitals"

Accreditation — "How to Get Ready for Accreditation"

Association Services — "Considerations in Capital Fund-Raising Campaigns for Hospitals"

Auxiliaries — "The Administrator and the Auxiliary Program"

Law — "Corporate Practice of Medicine"

Nursing — "Determining Staffing Needs (Within Hospitals)"

Organization — "How to Plan Hospital Organization"

Personnel Administration — "Hospital Management-Employee Relations"

Planning — "Community Planning for Hospital Services"

Professional Practice — "New Development in Hospital Pharmacy"

Reimbursement—"Development of Cost Reimbursement Contracts with Third Parties"

Safety — "Make Your Hospital Safe (and Save)"

Supervisory Training — "Inservice Training for Hospital Supervision"

Trustees — "The Trustee's Role in Planning for the Future"

12:15 p.m. — Federal hospitals' luncheon

2:15-4:15 p.m. — General session — "Utilizing Resources"

"Utilizing Community Resources" — Harrison M. Sayre, President, Columbus (O.) Hospital Federation

"Utilizing Contributed Services" — J. Stewart Baker, President, Chase Manhattan Bank, New York City

"Utilizing Industrial Resources" — Nathan J. Stark, Chairman, Community Chest, Kansas City Area Hospital Study Committee

"Utilizing the Resource of Knowledge" — Alan E. Treloar, Ph.D., Research Director, American Hospital Association, Chicago

Wednesday, September 19

9:30-11:30 a.m.

Conference on Hospital Planning

Round-table sessions:

Association Services — "Hospital Costs — What Associations Do to Help Control Them"

Auxiliaries — "Interesting the Whole Community in the Hospital"

Engineering — "Planning and Operational Problems of Air-Conditioning Systems"

Insurance — "Hospital Corporate Insurance Buying"

Methods Improvement — "Operations Research — Methodology for Evaluating the Quality of Patient Care"

Nursing — "Predicting Future Nursing Education and Nursing Service Needs"

Professional Practice — "Trustee, Administrator, Medical Staff Relations"; "What's New in Outpatient Departments"; "Control of Infection in the General Hospital"; "Problems of the Mental Hospital and the General Hospital Managing Mental Patients"; "Anesthesia in Small and Medium-Sized Hospitals"

Public Relations — "Planning for a Public Relations Program"

Reimbursement — "Hospital Rate Setting"; "Problems in Handling Commercial Health Insurance Claim Forms"

Supervision — "Training in Leadership"

12:30 p.m. — Sisters' Luncheon

2:15-4:15 p.m. — General session on "Meeting the Needs"

"A Concept of Total Care" — Howard A. Rusk M.D., Chairman, Department of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, New York City

"Community Hospital as Hub of Rehabilitation Facilities" — Joseph N. Schaeffer, M.D., Associate Medical Director, Institute of Physical Medicine and Rehabilitation, Peoria, Ill.

"Bringing Medical Services to the Aged" — Leonard O. Bradley, M.D., Administrator, Winnipeg General Hospital, Winnipeg, Manitoba, Can.

"Meeting the Needs of the Mental Patient" — Daniel Blain, M.D., Medical Director, American Psychiatric Association, Washington, D.C.

Thursday, September 20

9:30-11:30 a.m. — "Planning for Disaster"

"The Medical and Hospital Problems in the Care of Mass Casualties" — Col. Joseph R. Shaeffer, MC, Chief, Department of Atomic Casualties Studies, Walter Reed Army Institute of Research, Walter Reed Army Medical Center, Washington, D.C.

"Planning for the Field Tests" — Dean A. Clark, M.D., General Director, Massachusetts General Hospital, Boston

"Description of Test No. 1" — Col. Francis P. Kintz, MC, Surgeon, Headquarters Second Army, Fort George G. Meade, Md.

"Description of Test No. 2 and the Results of the Test Concepts of Casualty Care Services" — M. M. Van Sandt, M.D., Director, Medical Care Division, Health Office, Federal Civil Defense Administration, Battle Creek, Mich.

"Progress Report" — Harold C. Lueth, M.D., Chairman, AHA Committee on Disaster Planning, Evanston, Ill.

9:30-11:30 a.m. — Round-table sessions

Accounting — "Accounting for Large Hospitals"

Accreditation — "Accreditation Problem Clinic"

Association Services — "Small Hospitals Solve Large Problems"

Auxiliaries — "Organizing and Conducting a State Program for Hospital Auxiliaries"; "The Administrator and the Auxiliary Program"

Blue Cross — "Report on National Blue Cross Activities"

Engineering — "Functions and Organizations of the Hospital Engineering Department"

(Continued on next page)

Financing — "Financing Hospital Capital Requirements"

Methods Improvements — "Methods Improvement — Two Years of Progress"

Organization — "How Many Assistants Should an Administrator Have?"

Personnel — "Evaluating the Effectiveness of a Personnel Program"

Planning — "Programming the Hospital Project"

Professional Practice — "The Hospital and Changing Patterns of Medical Care"; "Problem Clinic for Children's Hospitals"

Public Relations — "Planning for a Press Relations Program"

2:15-4:15 p.m. — General session — "Hospital Professional Relations"

"The Physician" — Dwight H. Murray, M.D., Napa, Calif., President, American Medical Association

"The Nurse" — Ruth M. Sleeper, R.N., Director, School of Nursing and Nursing Service, Massachusetts General Hospital, Boston

"The Hospital" — Ray E. Brown, Superintendent, University of Chicago Clinics

"Blue Cross" — William S. McNary, Executive Director, Michigan Hospital Service, Detroit

"Blue Shield" — Francis T. Hodges, M.D., Vice-Chairman, Blue Shield Commission, San Francisco

it has equipment for surgery, anesthesia, and x-ray—some of which has been donated by interested groups.

This hospital also has an active tumor clinic—the first to be set up in a private hospital in this state. During the past year 964 visits were recorded, including new patients, and follow-up visits.

AHA visitors welcome, 1-4 p.m., during the week of September 17-21.

St. Mary of Nazareth Hospital, 1120 N. Leavitt St. Administrator: Sister M. Dechantal. 270 beds, 60 bassinets. AHA visitors welcome, 2-5 p.m. A year ago a new five-story building was opened to house 150 student nurses. It includes a large recreation and gym room. The former students' quarters have been reconverted into a doctors' staff room, with necessary equipment for lectures, meetings, etc., air-conditioned labor rooms, and a large x-ray department. All this was aided in part by a Ford grant.

St. Vincent's Infant and Maternity Hospital, 721 N. LaSalle St. Administrator: Sister Mary Antonia, R.N. Capacity 206 children; a fully equipped infant hospital for all abandoned, destitute, and neglected children, from newborn to three years. Because it is the only institution in Chicago and Cook County area to offer emergency care to children under three years of age, all police cases are referred there.

AHA visitors are welcome — from 10:30 a.m. - 12 noon and 2.30 p.m. - 4 p.m.

Salvation Army Booth Memorial Hospital, 5040 N. Pulaski. Superintendent: Major Gladys Fredericksen. 70 beds, 12 bassinets. AHA visitors welcome. A maternity hospital especially for unmarried mothers. This hospital hopes to have a full-time teacher for these girls this fall.

Shriner's Hospital for Crippled Children, 2211 N. Oak St. Director: Mable A. Ramspeck, R.N. 60 beds. AHA visitors welcome. All orthopedic work and follow-up care is given at this hospital until a child reaches 15 years of age.

South Chicago Community Hospital, 2320 E. 93rd St. 250 beds, 40 bassinets. Administrator: Clara D. Schafer, R.N. Visitors welcome. Hospital has a new dining room and cafeteria, and will be breaking ground for a two-story building in September—the first floor for an enlargement of the emergency room and the second floor for pediatrics. Miss Schafer will start her 37th year as administrator.

South Shore Hospital, 8015 Luella Ave. Administrator: Robert D. Fitch. 163 beds, 15 bassinets.

Swedish Covenant Hospital, 5145 N. California Ave. Administrator: Nils G. Axelson. 255 beds, 55 bassinets.

AHA visitors welcome. The hospital, observing its 70th anniversary, recently added a rehabilitation unit and is building a $500,000 addition to house the x-ray, laboratory, central supply department, and other services, to be ready the first of the year.

U. S. Public Health Service Hospital, 4141 Clarendon Ave. Officer in charge: G. P. Ferrazzano, M.D. 204 beds.

University of Chicago Clinics, 950 E. 59th St. Superintendent: Ray E. Brown. 681 beds, 120 bassinets. Beds are divided among the Billings Hospital, Lying-in Hospital, Bob Roberts Hospital, Argonne Hospital, and Home for Destitute Crippled Children. Visitors welcome — (one of four hospitals on tour list for AHA).

University of Illinois Research and Educational Hospitals, 840 S. Wood St. Medical Director: D. J. Caseley, M.D. 600 beds, 41 bassinets. There were 213,211 patient visits to the 29 clinics of the hospitals during the fiscal year ending June 30, an increase of 10,578 over the previous year.

The monthly average of patients treated in the emergency service at these hospitals has doubled since October, 1954, when the service began, and now averages 1,200.

AHA visitors welcome if they will telephone before coming out — MO 6-3900, extension 8105. Directions — within half a block from Polk Street Station on Douglas Park Elevated. Ten minutes from loop.

Veterans Administration Research Hospital, 333 E. Huron St. Manager: M. L. Matte, M.D. 305 beds.

Veterans Administration West Side Hospital, 820 Damen Ave. Manager: Lee H. Schlesinger, M.D. 488 beds. AHA visitors welcome. Scheduled group will be appreciated.

Walther Memorial Hospital, 1116 Kedzie Ave. Administrator: W. C. Bronert. 175 beds, 32 bassinets. Contract for air-conditioning the surgical and obstetrical departments was recently signed. Money received from the Ford Foundation will purchase new equipment. A 75-100-bed addition is being planned.

Waveland Manor Hospital, 3662 Lake Shore Dr. General Manager: M. A. Terman. 50 beds.

West Suburban Hospital, 518 N. Austin Blvd., Oak Park. Superintendent: L. C. Vonder Heidt. 329 beds, 100 bassinets. This hospital is involved in the preliminary work for the addition of a new building, which will increase the bed capacity by 70. Construction will start, it is hoped, this fall. Conservative cost estimate: approximately 2½ million dollars, including a Ford grant of $200,000.

Women's and Children's Hospital, 1600 W. Maypole Ave. Administrator: Katherine Ragan, 115 beds, 30 bassinets. This hospital, established by women and staffed entirely by women physicians, trains women interns and residents. It has the first and only cardiac kitchen in this area. Expansion is planned. A survey has been completed to add 60 more beds. Open house for AHA visitors September 20th, 1-4 p.m.

Woodlawn Hospital, 606 Drexel Ave. Business Manager: Bertha R. Judson. 150 beds, 15 bassinets. Hospital is turning kitchen over to commercial management.

AHA visitors welcome.

Setting Up a Tumor Registry

By Sister M. Flavian, C.R.L.*

Since January 1, 1956, a properly functioning tumor registry is a requirement for approval of a cancer program by the American College of Surgeons. It is not, as some persons erroneously believe, a requirement for accreditation of the hospital by the Joint Commission on Accreditation of Hospitals.

The minimum requirements for approval of a cancer registry, as set forth by the Committee on Cancer of the American College of Surgeons, stipulate that the cancer program must be conducted either in and by the staff of a hospital approved by the Joint Commission on Accreditation of Hospitals or, in lieu of this, by an organization, the cancer program of which has the formal approval of the local county medical society. There must be a committee on cancer consisting of physicians directly concerned with the diagnosis and treatment of cancer. The committee's duties shall be to initiate, supervise, and appraise the cancer program and to report to the medical staff at least annually.

There are three types of approved programs: (1) A tumor registry only (this is a requirement for all programs), (2) a cancer consultation service, and (3) a cancer consultation and treatment service. The cancer registry is an integrated unit in the administrative organization of the cancer program "established under the general jurisdiction of the Committee on Cancer."

The purposes of the registry are:

(1) To record from a specified date, the names of all cancer or cancer suspect cases, both inpatients and outpatients.

(2) To have available a file of abstracts with a resume of diagnosis, treatment, and follow-up for evaluating, teaching, research, and reporting purposes.

(3) To provide a systematic follow-up of all cancer patients to keep them under adequate medical observation as long as they live. This information must be added to the abstracts of the patients.

(4) To report to the staff annually their cancer salvage rate.

In setting up a cancer registry two things should be kept in mind: the type of institution in which the registry is maintained—that is, general or specialized or cancer clinic—and the type of cancer program being carried out in the hospital.

The three minimal records needed for the operation of a registry are a cancer abstract form, space for follow-up, and an accession record.

The choice of forms, filing equipment, etc., should be based on the size and special needs of the particular institution employing them, but, whatever choice is made, the following equipment will be necessary: history cards or sheets, a system of follow-up, indexing materials or cards, an accession register, form letters, stationery, stamps, and a file in which to house the records.

There are several systems for cancer registries which may be used. All of them meet the requirements set down by the American College of Surgeons for maintenance of a tumor registry. The system used in our hospital utilizes the case history abstract form illustrated in the revised *Manual for Registries and Cancer Clinical Activities*, published in 1955 by the American College of Surgeons. The follow-up record is on the back of this form, so that only one card plus an accession register need be used.

Figure I is the abstract form used in our cancer registry. The source of information for preparing this form is the medical record. Particularly in the general hospital without residents, this seems to be the only logical source of information and the medical record department the only logical place to house the cancer registry.

The abstract form must be prepared with the utmost care and accuracy if it is to be a valuable future reference. Hence, the medical record must be carefully and accurately prepared, especially in regard to dates of diagnosis, exact histological diagnosis in previously diagnosed cases, and previous treatment.

If the record is lacking in details, such as the date of diagnosis, the basis for the diagnosis, specific treatment, and other items, the attending physician must be consulted and asked to supply this information. It may be necessary to call other hospitals or doctors if the attending physician cannot supply the information.

At St. Francis Hospital in LaCrosse, Wis., the record librarian fills out as much of the form as she can from the medical record, and the pathologist completes the more technical details, such as whether the treatment was curative or palliative, whether there was clinical evidence of cancer, and other pertinent information.

The abstract form is not a duty which may be performed by untrained, unskilled workers. The person in charge of the cancer registry must be intelligent and must have a good knowledge of methods of record-keeping, filing, and indexing. It would be well for her to have special knowledge regarding malignant tumors. She should endeavor to increase her knowledge of this subject. She must possess tact, ingenuity, and perseverance.

All the information on this basic record is important. More than one basis of diagnosis may be checked. The

(Continued on next page)

*Sister Flavian is chief medical record librarian, St. Joseph's Hospital, Milwaukee, Wis.

Forms shown in Figures I, II, and III are available from the Medical Case History Bureau, New York City.

date of diagnosis should be that on which the diagnosis was definitely established. Previous treatment should be briefly but specifically recorded, e.g. radium—3500 mgm. hrs. to cervix, rather than radiation therapy; resection of the splenic flexure of the colon and anastomosis, rather than laparotomy; insertion of 150 mc. of radioactive colloidal gold into the abdominal cavity, rather than insertion of radioactive substance.

In checking the type of treatment, definite explanation is also required. The dates of treatment, the dosage, and the area treated should be accurately recorded in the space provided. Under name and address of hospital or physician responsible for follow-up, the names of all possible sources of contact should be recorded, together with addresses and phone numbers of such possible contacts.

At the top of the abstract form, space is provided for complete indexing of the record. Spaces 14 through 20 are provided as an automatic cross-index of cancer sites. The "International Statistical Classification" is used. The code numbers are printed on colored cards—a different color for each system of the body. Colored tabs, corresponding in color with the International Statistical coding cards, are pasted over the corresponding numbers on the abstract form after the third and fourth digits are completed. Thus all cases occurring in the same system will appear in the same column in the files, and it will be very easy to pull from the file all malignancies occurring in a given organ.

In coding according to the International Statistical Classification, care should be used in assigning numbers to a particular site, because in a few instances there is a different code for a primary site and a secondary site.

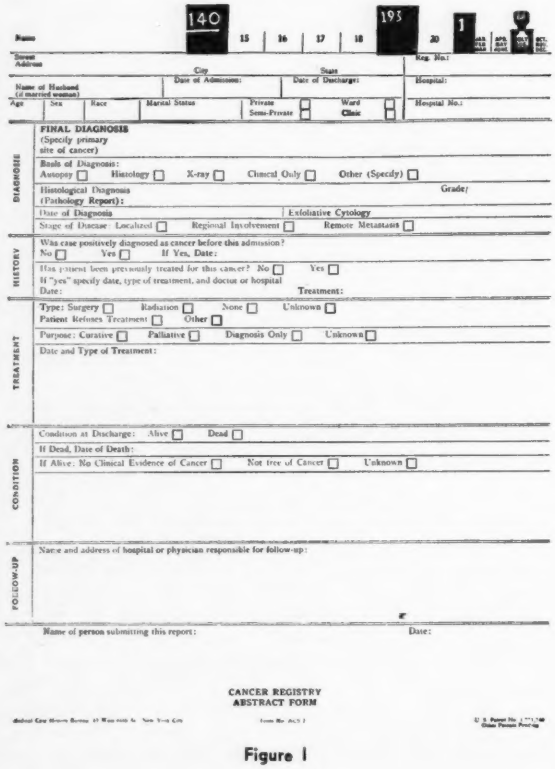


Figure I

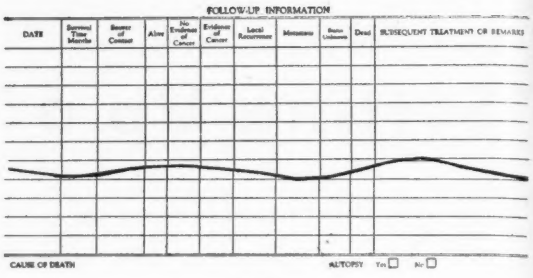


Figure II

For example, under malignant neoplasms of the respiratory system, code 162 is used for malignant neoplasm of trachea and of bronchus and lung, specified as primary site. On a yellow supplementary card, there is a more complete breakdown of this code, specifiying 162x for lung, 1621 for bronchus, 1622 for trachea, etc. Referring back to the blue code card for malignant neoplasm of the respiratory system, one will find code 163—malignant neoplasm of lung and bronchus, unspecified as to whether primary or secondary, and 165—malignant neoplasm, lung, bronchus, secondary. The liver is another organ for which separate codes are given for primary and secondary lesions.

Lymphosarcoma of any site—stomach, intestinal, retroperitoneal or regional—is classified under the lymphatic and hematopoietic tissues and would receive the code 200.1 rather than the code of the specific organ.

It is desirable that metastatic sites be coded, but there should be some differentiation to show that they are secondary sites. In our hospital, this is done by underscoring the secondary site. We do not code more than two metastatic sites. A patient having three or more metastatic sites receives the code 199 underscored to show that there are multiple metastases. On cases with more than one primary site, an abstract is prepared for each primary site with cross-reference.

When the primary site is determined, after having been recorded as undetermined, this correction should be made on the abstract card and the correct index tab placed.

A tab with the physician's code number is pasted over the column marked Ref. Both codes are recorded if more than one doctor is in attendance.

A simple system of follow-up is provided in the four last spaces at the top of the abstract card. Unless the attending physician or the policy of the cancer committee specifies otherwise, all patients should be followed once a year until death. Colored tabs bearing the month in which the patient is to be followed are placed over the designated column. These signals are changed as the follow-up dates change. When the patient dies, the follow-up signal is replaced by a black tab to the extreme right of the record.

The back of the abstract record (Figure II) carries a simple check-off form for follow-up information. Follow-up date is the one on which the patient was seen and examined by the physician, the date of correspondence from the patient or relative, or the exact date of death. One should not be satisfied with approximate dates if it is at all possible to secure exact dates. The survival time is calculated from the date of diagnosis and should be filled in at the time the follow-up information is recorded. Metastatic sites may be added in the "remark column"

PRIMARY SITE NO.

CASES REPORTED FROM 195 —TO 195

REGISTRY CASE NUMBER	HOSPITAL CASE NUMBER	PATIENT'S NAME	RACE	SEX	AGE	DATE OF DIAGNOSIS	HISTOLOGICAL DIAGNOSIS	STAGE	TREATMENT	DATE OF DEATH	SURVIVAL TIME MOS.

Figure III.

after the metastatic column is checked, or the site may be written in the metastasis column instead of indicated by the check mark.

After we complete the abstract form, we enter the case in the accession book (Figure III). We use colored sheets in the accession book corresponding with the colors of the index tabs on the cards. With this method there is again an automatic classification within a given system or, if preferred, a given organ of the body. The accession number is also placed on the abstract card immediately below the follow-up months.

The numbers may be assigned according to various methods, but it seems impractical to assign continuous serial numbers if colored sheets are used. The assignment of numbers corresponding with primary site codes placed

(Continued on next page)

RECAPITULATION SHEET

	14	150	151	153	15	162	16	170	171	172	175	177	17	180	181	199x	19	200	204	TOTALS
1949	13	7	30	32	51	9	2	62	22	20	5	22	5	7	16	9	12	17	9	350
1950	15	11	25	40	63	11	5	69	30	19	4	19	9	6	19	13	11	21	11	401
TOTALS	28	18	55	72	114	20	7	131	52	39	9	41	14	13	35	22	23	38	20	751

Figure IV.

ST. JOSEPH'S HOSPITAL
5000 W. Chambers, Milwaukee, Wisconsin

Dear Doctor:

Would you kindly let us know the present condition of the following patients whom you have treated here in the past, so that we may be able to complete our follow-up records on carcinoma? We would greatly appreciate your returning this form by

In the event that you are unable to supply us with information on one or other of these patients, may we have your permission to contact the patient, or relative of the patient? Yes ____ No ____

Patient's Name and Address	Date last seen	Alive	No Evidence of Cancer	Evidence of Cancer	Local Recurrence	Metastasis	Status unknown	Date Dead	Subsequent treatment or remarks

Thank you, Doctor, for your cooperation in this matter.

Sincerely yours,
Sister M. Flavian, C.R.L.

Figure V.

at the head of each sheet of the accession book seems more workable. For ease in gathering statistics we have devised the following method, which has proved quite satisfactory.

The accession sheets were labeled with International Statistical codes according to general and specific classification based upon frequency of occurrence in our hospital: namely, 14—malignant neoplasms of buccal cavity and pharynx; 150—esophagus; 151—stomach; 153—large intestine; 154—rectum; 15—other digestive organs and peritoneum; 162—bronchus and lung; 16—other organs of the respiratory system; 170—breast; 171—cervix uteri; 172—uterus; 175—ovary; 177—prostate; 17—other genital organs; 180—kidney; 181—bladder and other urinary organs; 200, 201, and 202—the lymphomas; 204—the leukemias; 20—other neoplasms of lymphatic and hematopoietic tissues; 199x—unknown primary site, and 19—malignant neoplasms of other and unspecified sites.

Accession numbers begin with No. I for each diagnostic category and continue in sequence until the end of the year. The following year the count again starts with number one. In order to distinguish cases in the different categories, the classification code precedes the accession number. The last two digits of the year complete the case number. For example: A case diagnosed "duct-cell carcinoma of the breast" is classified 170. If it is the tenth duct-cell carcinoma case for the year 1955, the case number will read 170-10-55. The serial number, of course, could be carried on indefinitely instead of starting with number one each year.

The histological diagnosis may be written out or the Standard Nomenclature codes may be used. Treatment is recorded in code; SC for surgery, curative; SP for surgery, palliative; capital R for radium; small r for radon; X for x-ray; C for chemotherapy (this would include such therapy as nitrogen mustard, aminopterin, teropterin, ACTH and cortisone); H for hormones, such as stilbesterol, testosterone, and others. Radioactive isotopes should be specified, e.g., radioactive colloidal gold—Au^{198}, radioactive phosphorus—P^{32}, or radioactive iodine—I^{131}, and O for none.

At the end of the year the totals from each category of the accession register are transferred to a recapitulation sheet (Figure IV) which is kept in the accession book. The totals to date may be added in small red numbers just beneath the line of the latest recorded year to show the total cases in each category and the total number of cases entered in the registry.

The follow-up of cancer patients is an essential part of a cancer registration service. In fact, the underlying reason for registries is to assure this follow-up.

In an article entitled, "Follow-Up of Cancer Patients," written by John B. Graham, M.D., and E. Patricia Wolfson and published in the September-October, 1955 issue of *Cancer*, Dr. Graham states: "For 40 or more years it has been recognized that the immediate apparent eradication of tumor by surgery or radiation is not a reliable guide to cure. About half the recurrences occur in the first year after treatment, with progressively fewer in

St. Joseph's Hospital

5000 W. CHAMBERS ST.
MILWAUKEE 10, WIS.

Dear

We are making a special study to obtain full information about patients who were treated at St. Joseph's Hospital for such conditions as you have had. Information made available by such studies helps us in the care of other patients with similar trouble. Would you kindly cooperate by answering what you can and returning.

What is the condition of your general health at present? _____

_____

Have you had any further medical, or surgical treatment since leaving this Hospital? If so, please describe briefly. _____

_____

Who is your doctor now? _____

His address is: _____

Who other than your (husband, wife) will always know your address?

Name _____ Relationship _____

Address _____

Any further comments you may wish to make may be written on the reverse side of this letter. Enclosed is a stamped addressed envelope for your convenience in replying.

Sincerely yours,

Sister M. Flavian, C.R.L.
ST. JOSEPH'S HOSPITAL

If for any reason the person to whom this letter is addressed is unable to answer it, will a relative, or friend please supply as much information as possible, with the date the patient was last seen.

Figure VI.

succeeding years. It is probable that less than 10 percent turn up after five years, so the five-year figure has come to be a useful index of success. However, the usefulness of the five-year cure as the principal measure of cancer treatment is frequently impaired by an inability to follow all the patients in a series for that length of time. With effort, it is possible to trace virtually all patients, if advantage is taken of the available facilities."

Once a month the secretary of the registry goes through the files and pulls the cards with follow-up tabs of the current month. She arranges the cards according to the doctor's code numbers. As she does this, she watches the source of contact column on the follow-up form and removes any forms, the source of whose last contact was any other but the attending physician.

She then completes form letters to all doctors on each case, including the patient's name, address, diagnosis, and date last seen at the hospital. (See Figure V).

For those patients whose follow-up was last received from a source other than the attending physician, letters are written to the source of contact which last yielded positive information on the patient (See Fig. VI).

The correspondence is counted and recorded in a book kept for that purpose. The abstract cards are then alphabetized and kept in a separate drawer of the file until the follow-up is returned.

Responses to follow-ups are returned to the hospital with amazing rapidity. The letters, whether complete or otherwise, are dated as they are returned and kept in a folder until the secretary is ready to post the results of follow-ups.

Before the posting procedure is begun, the returns are again counted and the number recorded in the book mentioned previously. As much of the correspondence as is possible is alphabetized, and these follow-ups are posted first.

As one posts, the survival time in months up to the present should be calculated and posted along with the other pertinent information. This is not absolutely necessary unless the patient is deceased, but is very helpful when studies are being made. Subsequent treatment should be posted specifically but briefly and to the point.

The letters giving detailed accounts of diagnosis, treatment, or condition of the patient may be filed with the abstract form or may become a part of the patient's hospital record, depending upon the policy set down by the committee on cancer. Care should be taken to add new sources of contact or to change old ones.

If there is a change in physician, the code number on the physician's tab may have to be changed, unless this tab is used for other purposes, as it is in our hospital. (Recently we had occasion to pull all the cancer abstracts of one of our staff doctors. It was a delightful experience to be able to pick them out with great speed.) When posting deaths, one should enter at the bottom of the form the cause of death and whether or not an autopsy was performed.

As follow-up entries are completed, the abstract forms are separated into three stacks—living patients in one, deaths with exact dates of decease in another, and untraced in a third. Deaths without exact date of demise are included with untraced. The forms for the living patients may be dispensed with first. If necessary, the follow-up tabs are changed so that the next contact will be one year, or otherwise, from date of the last contact.

Because follow-up information is not always current, care should be taken to record the date of the contact rather than the date the follow-up was received. The abstracts of the living patients may then be filed back into the master file.

The follow-up tabs are removed from the forms of

RESULT OF FIRST THREE-YEAR FOLLOW-UP

1949 - 1952

	TOTAL	LIVING			DEAD	UNTRACED
		WITH CA.	WITHOUT CA.	COND. UNKNOWN		
All Sites	350	46	78	8	213	5
1. Breast	62	11	18	4	29	-
2. Rectum & rectosigmoid	39	3	7	-	28	1
3. Colon	32	2	12	-	18	-
4. Stomach	30	-	-	-	28	2
5. Cervix	22	1	8	2	10	1
6. Prostate	22	7	3	-	12	-
7. Uterus	20	4	10	-	6	-
8. Lymphomas	17	3	1	1	12	-
9. Bladder	16	4	5	-	7	-
10. Buccal cavity & pharynx	13	1	3	-	9	-
All others	77	10	11	1	54	1
% of follow-up	98%					

RESULT OF FIRST FIVE-YEAR FOLLOW-UP

1949 - 1954

	TOTAL	LIVING			DEAD	UNTRACED
		WITH CA.	WITHOUT CA.	COND. UNKNOWN		
All Sites	350	13	46	4	261	26
1. Breast	62	5	6	4	41	6
2. Rectum & rectosigmoid	39	-	5	-	31	3
3. Colon	32	1	9	-	21	1
4. Stomach	30	-	-	-	29	1
5. Cervix	22	-	5	-	12	5
6. Prostate	22	-	2	-	19	1
7. Uterus	20	1	9	-	8	2
8. Lymphomas	17	1	1	-	15	-
9. Bladder	16	2	2	-	10	2
10. Buccal cavity & pharynx	13	-	-	-	11	2
All others	77	3	7	-	64	3
% of follow-up -	93.5%					

Figure VII.

the deceased patients and replaced with black tabs to the extreme right of the cards to indicate the deaths of the patients. The cards are arranged according to accession numbers, and the date of death and survival months are recorded in the accession register. The abstracts may then be filed in the master file.

The third stack of abstracts—the untraced patients—will require further correspondence. Any information which has been received should be added to the form.

(Continued on next page)

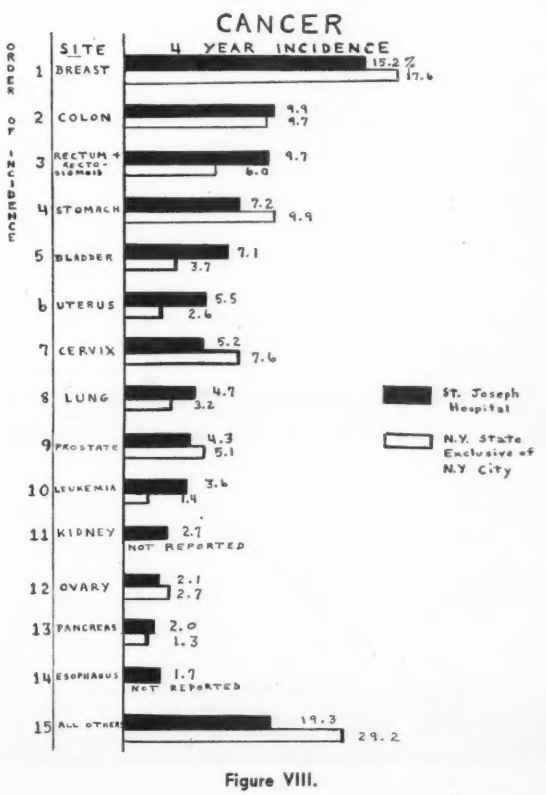

CANCER
4 YEAR INCIDENCE
ORDER OF INCIDENCE
SITE
1 BREAST 15.2 % 17.6
2 COLON 9.9 9.7
3 RECTUM + RECTO-SIGMOID 9.7 6.0
4 STOMACH 7.2 9.9
5 BLADDER 7.1 3.7
6 UTERUS 5.5 2.6
7 CERVIX 5.2 7.6
8 LUNG 4.7 3.2
9 PROSTATE 4.3 5.1
10 LEUKEMIA 3.6 1.4
11 KIDNEY 2.7 NOT REPORTED
12 OVARY 2.1 2.7
13 PANCREAS 2.0 1.3
14 ESOPHAGUS 1.7 NOT REPORTED
15 ALL OTHER 19.3 29.2
St. Joseph Hospital
N.Y. State Exclusive of N.Y. City

Figure VIII.

This may be the suggestion of another source of contact or the fact that the patient has died without giving the exact date of death or the cause of death, although in some instances it can safely be assumed that the cause was cancer.

It may be that a letter was returned unopened. At our hospital recently we were unable to obtain follow-up information from a doctor, who said the patient had moved upstate to a town which he named, and that he thought the patient had died since. We had only the name of a brother without an address in our files and so had no other source of contact. Taking a chance, we sent a letter to the patient. It was returned a few days later with this notation: "Mr. X deceased in 1952. A brother, XX, living at such-and-such a place."

This was just the information we wanted. We wrote to the brother, telling him that we had information that his brother had died in 1952 and wondered whether he would tell us the exact date and the cause of his death so that we could complete our files on his case. We received a very courteous reply from him giving us all the desired information.

The cause for non-delivery of letters is noted on the follow-up form and the cards on all untraced patients replaced in the file awaiting follow-up information. The following month, when the follow-ups are again sent out, these are included, using another source of contact in an effort to get the desired information.

In following our patients, our first contact is with attending physicians, then the patient himself or relatives, then the agency administering the official state cancer program. In Wisconsin, this is the State Board of Health, Division of Cancer Control, Madison 2. A law passed in Wisconsin in 1933 made cancer a reportable disease for that state.

Other sources of follow-up which may be helpful are the city directory, employers, social agencies and, especially, central registries. The Bureau of Vital Statistics will supply cancer registries with cancer mortality lists upon request and sometimes the payment of a fee.

In areas with a fixed population, checking the obituary notices in the daily newsaper is most helpful in establishing the fact of death. This saves much time and effort, since the knowledge of death precludes the necessity of following the patient further.

What is to be done with untraced cases when every possible contact has proved fruitless is a problem which will have to be decided in the individual institution. However, sometimes cases with which contact has been lost for a number of years again become traceable.

Besides the annual report of the current work of the registry, five-year end results must be reported to the medical staff, as they become available through continuing follow-up. Use of an asterisk in the accession register or a special tab to the extreme left of the abstract card will provide a quick means of spotting five-year cures.

Some of the results of follow-up in our hospital over the past seven years are shown in Figures VI, VII, and VIII.

SUMMARY

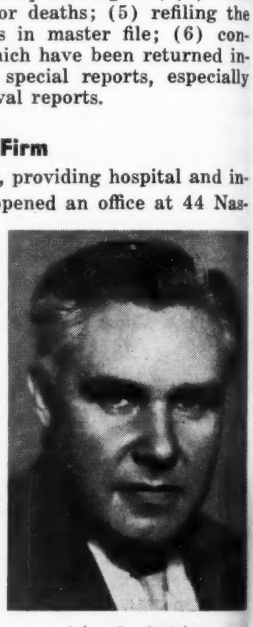
A cancer registry is a requirement for approval of a cancer program. Equipment consists of abstract cards with a system of follow-up included on the card, colored tabs for indexing, and metal tabs showing month of follow-up, accession register, file, form letters, and a few miscellaneous items.

Steps in setting up the registry are: (1) preparing the abstract; (2) indexing the card; (3) accessioning the record; (4) filing the record.

To maintain the registry, the following steps are necessary: (1) sending out monthly follow-ups; (2) posting follow-ups; (3) changing follow-up date signals; (4) completing the accession record for deaths; (5) refiling the cards on completed follow-ups in master file; (6) continuing follow-ups on those which have been returned incomplete, and (7) preparing special reports, especially the annual and five-year survival reports.

Steinle Opens Consulting Firm

John G. Steinle and Associates, providing hospital and institutional consultation, have opened an office at 44 Nassau Blvd., Garden City, N. Y.



John G. Steinle

Mr. Steinle has been principal in charge of hospital work for Cresap, McCormick and Paget, management consultants, for three and a half years. Prior to that, he was hospital program director for the New York and Boston regional offices of Public Health Service. He was also formerly administrator, St. Louis City Infirmary.

Mr. Steinle plans to open a Chicago office shortly.

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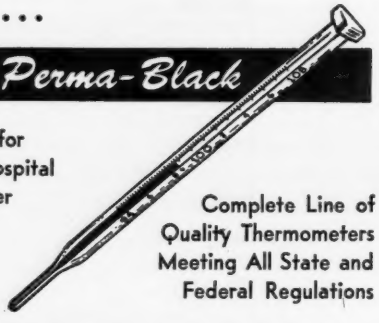

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Why We Reopened Our Nursing School

By Warren R. Von Ehren *

One of the most perplexing problems facing hospital administrators today is that of providing sufficient and adequately trained personnel to staff the hospital. This is especially true in smaller hospitals located in rural areas or in cities removed from large metropolitan centers.

It has long been my feeling that a hospital, regardless of its size, must train many of its own personnel, if it is to have an adequate staff. This most hospitals have been doing for a number of years, primarily by on-the-job-training programs, such as have been developed for nurse's aides, orderlies, clerical workers, etc.

However, the hospital under 150 beds has generally been unable to finance the training of professional personnel, such as interns, residents, graduate nurses, technicians, etc., with any degree of success. Educational programs are expensive and virtually impossible for the smaller hospital with limited resources to carry on effectively.

The fact still remains that the small hospital, just as much as its larger sister in the metropolitan areas, needs a continual source of trained professional people, especially graduate nurses, if it is to continue to offer a high level of patient care. Even though hospitals are utilizing subprofessional personnel with greater effect today than was true 10 or 20 years ago, and these persons play a very important part in good patient care —there is a certain irreducible minimum number of professionally trained personnel that are required to effectively carry out its program of patient care.

Like all hospitals, we were and are faced with a shortage of graduate nurses. Our hospital previously operated an approved nursing school which was closed several years ago because of a lack of adequate housing for students and lack of a qualified faculty. During the years our school was in operation, the problem of recruiting graduate nurses was not as great as we found it to be after our school was closed. Although our hospital is located in a fair-sized community (population approximately 58,000) we found it increasingly difficult to attract graduate nurses to our staff.

This was not because of any deficiencies in our personnel policies or in our wage scale, since both compare favorably with those of other hospitals, even hospitals in metropolitan areas. It is a problem common to most hospitals in communities like ours that there is nothing especially attractive to a single young woman, especially those with matrimony in mind, in living in a smaller community.

We found, too, that young women from our community and outlying rural communities, who were interested in entering training, had to go some distance away—such as Milwaukee, Madison, or Chicago—to enter a school. This was especially true for Protestant girls who, because of individual preference, did not wish to enter a Catholic school of nursing. In most cases, when these girls went away from their home community, they did not return upon completion of their training, but remained in the community in which they took their training or moved on to larger cities.

(Continued on next page)

* Administrator, Bellin Memorial Hospital, Green Bay, Wis.

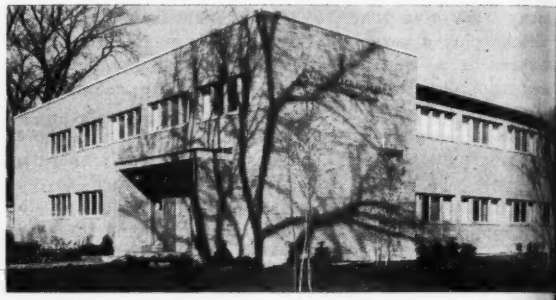
A nursing arts class session located in a dormitory classroom is pictured above.

Above: Students use the recreation room that has facilities for shuffleboard, ping pong and informal parties.

Faced with the problem of recruiting an adequate supply of graduate nurses to keep our own hospital fully staffed and also realizing that we are a somewhat larger hospital located in a predominantly rural agricultural area, we felt a definite responsibility to seriously consider reopening our school of nursing—to help train graduates not only for ourselves but also for outlying areas. We did not embark upon this project without being fully aware of the many problems we faced in re-entering the educational field. We carefully considered the fact that the problems in reopening a nursing school would fall into four or five general areas:

(1) Difficulty in recruitment of faculty
(2) Expense to the hospital in operating a school and the necessity for adequate financial support
(3) Provision of adequate housing for students
(4) Recruitment of students
(5) Provision of an adequate educational program.

Since we opened our school, the problems outlined above have been solved partially or wholly as follows,



Pictured above is an exterior view of the Bellin Memorial Hospital School of Nursing in Green Bay, Wisconsin.

although I would be the first to say that many problems still face us:

(1) As far as recruitment of faculty is concerned, two people from our faculty of the old school, who had stayed on in nursing service, returned to positions on the faculty. Fortunately, another member of our nursing staff, who was working on a part-time basis as a staff nurse, was qualified as an instructor, and she was appointed to the faculty. We employed a well-qualified person as director of nursing service and education and also a person to serve as educational director.

At the present time, two of our staff members are attending universities with scholarship aid from the State Department of Nurses and a small stipend provided by the hospital. In exchange for this aid, these two persons have agreed to return to us and spend a minimum of two years on our faculty. When they have completed their academic work, they will be eligible for positions as instructors.

Our head nurses and assistant head nurses are qualifying as faculty members by attending the University of Wisconsin extension center in Green Bay, where special courses have been arranged by the University in subjects needed to qualify them for teaching responsibilites. The hospital pays none of their expenses but does give them time off with pay to attend classes.

(2) The school has been an expense to the hospital, and our problem of adequate financial support has not been completely solved as yet. At the present time the

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Dextran is, of course, not intended as a substitute for whole blood. If hemorrhage accompanies the shock, it is essential to correct your patient's acute anemia by blood transfusion. Here Dextran will tide over the emergency while blood is being obtained, or where blood and plasma are not available.

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costs of operating the school are coming from patient fees, although we hope to engender the support of the Methodist churches in the Wisconsin conference which actually owns the hospital.

We were fortunate to secure $10,000 from a local industry for the provision of a new library for the school and from the same concern a grant of $5,000 for scholarships. We have also received some additional scholarship money and hope that other funds will be available for this purpose over a period of time. We have had a great deal of interest evidenced in our school not only by our own community but other surrounding communities. We hope that over a period of time adequate financial support will be forthcoming, and we have every reason to believe that this will be true.

(3) To provide adequate housing for students, we conducted a community campaign two years ago to raise funds to build a new dormitory. The money thus raised, together with a grant of funds under the Hill-Burton act, enabled us to erect a new dormitory which will house 78 students and includes some classroom space, at a total cost of $350,000 for land, equipment, and architectural fees. This provides our school with a very modern and complete dormitory which will serve our needs adequately for now and the future.

(4) In recruitment of students, we have noted a lot of interest among high school seniors in the area, especially those in the rural communities. The first year, for example, we had more than 90 letters of interest from girls and had a total of approximately 50 applications for admission to the school, from which 31 students were finally selected. Contacts are made with students through "Career Days" at high school and referrals from teachers, vocational counselors, and pastors. We received some 30 applications for the class being admitted in September. Recruitment, it appears, will not be a particularly difficult problem, and we have been pleasantly surprised to find that the quality of applicants is high and we are able to select good material for the school.

(5) Our educational program is being geared to meet not only state requirements, but also eventual accreditation by the National League for Nursing. We have already received probational approval from the State Department of Nurses and are confident that full approval will be forthcoming as soon as the school has been in operation one year, the minimum length of time required before a school can be fully approved.

We have had fine cooperation with the University of Wisconsin extension center in the teaching of the preclinical nursing subjects, i.e., chemistry, microbiology,

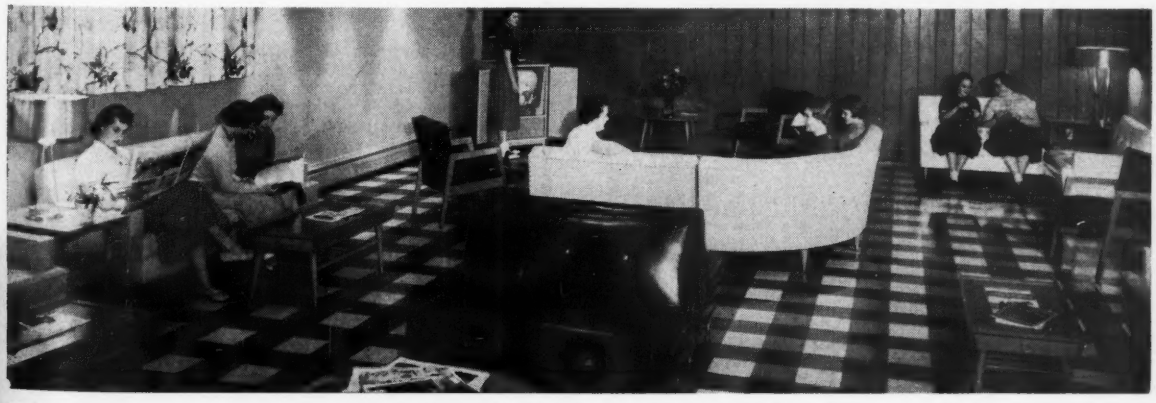
Pictured above are a group of students enjoying coffee hour in the informal floor lounge. Each floor has a lounge similar to this one.

etc. The extension center has very good facilities and has recruited, in many cases to meet our own students' requirements, an excellent faculty. Our students receive credit for certain of these classes, on the same basis as other university students, and take others on a noncredit basis.

The Green Bay Vocational School teaches our students the course in foods and cookery (nutrition), provides very excellent laboratories, and also employs the instructor and pays her salary. While we have much to do in the development of our educational program, we feel that we have made a start in the right direction for the eventual development of a sound diploma program in nursing.

While it is still too early to draw any definite conclusions, we are not sorry that we embarked on this program, even with all the problems we have had and the many that will face us in the future. Our board of directors, the medical staff, and the entire community are completely behind our program, and it is only a matter of

(Continued on next page)



Students may receive guests in the main lounge which includes television and a small fiction library.

(Continued from page 25)

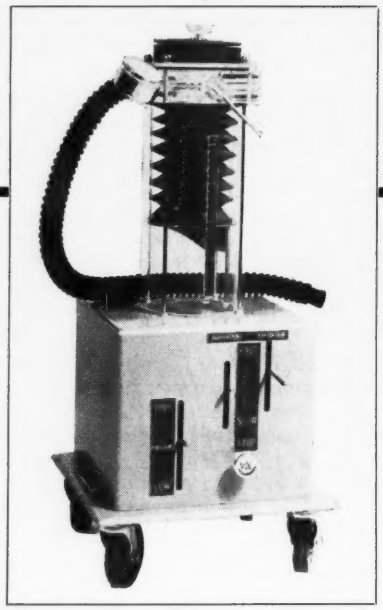
time, I am convinced, until we can develop their support to the point where our school will be on a sound financial and educational basis. We consider these to be the primary benefits to the hospital so far from the reactivation of the school:

(1) Our public relations with the community, the medical staff, etc., have been improved considerably, since all of these groups are enthusiastic about the program. We also feel that the school has put the hospital on the map, so to speak, and we are rapidly becoming known as a teaching institution.

(2) We have made a definite improvement in patient care in planning our educational program, because we have had to take a long look at our patient care program and revise it in the light of the experience that must be provided for students. Even though students spend only a short period of time on the nursing floor now, the mere fact that they are in the hospital has served to put our entire staff, medical, nursing, etc., on its toes and has made it more aware of its responsibility, both from the patient care standpoint and the teaching standpoint.

(3) Having a school of nursing has helped in the recruitment of personnel, especially graduate nurses, since we have found it somewhat easier to be able to attract personnel on the strength of having an educational program. Many of these persons are anxious to be associated with a hospital that has an educational program.

Above: Here is a student room. There are two students in each room. Each student is provided with a dresser desk, studio bed, accommodation vanity table. Lavatory and closet space is provided.



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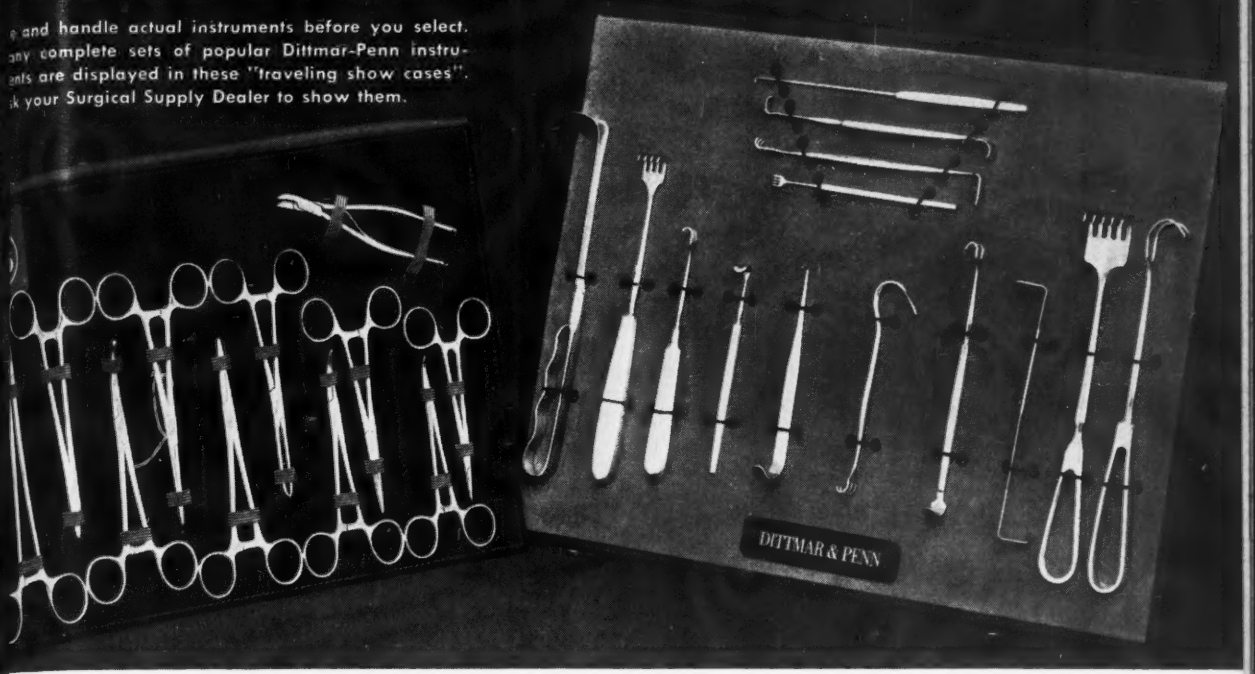

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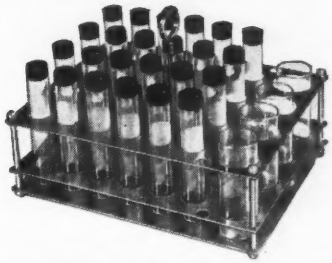

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La Mesa Community Hospital Medical Staff Meets in Hawaii

Above: D. E. Bennett, M. D., La Mesa Community Hospital, and John H. Gorby, administrator, demonstrate chop-stick technic at luncheon at Ishii Japanese tea garden, given by host doctors in Honolulu.

• Administrator John H. Gorby, La Mesa (Calif.) Community Hospital, has the system for making everyone want to attend medical staff meetings. He plans an excellent program for the staff's annual clinical session, to be put on in a desirable vacation city.

Forty-four persons attended the fourth annual session, held at the Tripler General Hospital, Honolulu, Hawaii, June 18-20. The subject was disaster planning. The three previous annual meetings have been in Mexico City.

Plans for the meetings are started almost a year in advance. The program—to be approved as a postgraduate course—must contain material not available in the hospital's own community and must include men from the community in which the meeting is being held.

As a result of the 1956 program, Honolulu plans to send a committee to San Diego to study the city's disaster plan, which, Mr. Gorby says, is perhaps the only complete one in the nation.

Mayor Charles E. Dail, San Diego, Calif., gave the keynote address on "Lay Participation in Disaster Planning."

Shoes were shed and kimonos donned for lunch at the tea garden. Shrimp tenpura, sukiyaki, rice, raw fish, vegetable, tea, and warm sake were on the menu. San Diego's Mayor Charles E. Dail (third man from front, right-hand row) went with the staff and presented a paper on civilian disaster planning.

The staff went to a luau at Don the Beachcomber's. Pictured (l. to r.): C. J. Miller, M.D., Mrs. Charles Chandler, Mrs. Miller, Lou Glasgow, M.D., Viola Erlanger, M.D., Rosemary Nuanunu (hula dancer), Mrs. Ida Collins, Fred Ullrich, M.D., Dr. Chandler, and Mrs Ullrich.

J. C. Wang, M.D., associate radiologist, Queen's Hospital, Honolulu, talked on "Monitoring Radiological Casualties." Gerald C. Crary, administrator, Scripps Memorial Hospital, La Jolla, Calif., ended the first day's sessions with a discussion of "Organizing a Local Hospital for a Disaster."

Lester L. Wilcox, M.D., chief of staff, La Mesa Community Hospital, opened the Tuesday sessions with "Treatment of Burns." Mildred Cotterill, R.N., surgical supervisor at La Mesa, spoke on "Supplies and Equipment." Francis H. Woo, chief, bureau of industrial hygiene, Department of Health, Honolulu, gave a demonstration of radiological monitoring. Mr. Gorby spoke on "Problems of Disaster Planning."

Charles J. Miller, M.D., La Mesa, opened the final day's session with a lecture on management of trauma. Marvin P. Baecker, M.D., chief of pediatrics, Long Beach (Calif.) Community Hospital, spoke on "Pediatric Complications Following Radiation Exposure."

George M. Johnson, M.D., Phoenix, Ariz., talked on immediate care of radiation exposure, and Clyde Kimmell, M.D., Los Angeles, discussed late care of radiation exposure.

Maine Association Holds Annual Meeting

• Approximately 150 hospital administrators, trustees, and department heads attended the recent two-day session of the Maine Hospital Association, at the Hotel Samoset, Rockland, Me.

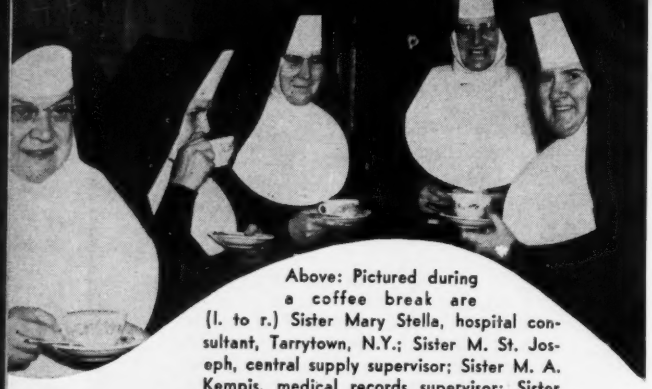
Instructional conferences on dietary problems in hospitals of all sizes filled the first afternoon's agenda. Maria Carey, dietary consultant, Bingham Associates Fund, New England Center Hospital, Boston, spoke on "Suggested Solutions for the Problems of Small Hospitals." Etta M. Dodge, R.N., assistant administrator, Brunswick (Maine) Community Hospital presided.

Mrs. Theodore E. Hardy, administrator, Hyde Memorial Rehabilitation Hospital, Bath, presided over a conference called "Let's Talk About Nursing Service." Phyliss Caswell, nursing consultant, Bingham Associates Foundation, New England Center Hospital, Boston, was the discussion leader.

Alice W. Schindel, R.N., director of nursing, Central Maine General Hospital, Lewiston, spoke on education, and Henry X. Jackson, administrator, Knox County General Hospital, Rockland, on administration. Mrs. Avis Boardman, R.N., Thayer Hospital, Waterville, talked on nursing service. The practical nursing service was discussed by Frances E. Jordan, R.N., director, practical nursing program, Aroostook State Teachers' College, Presque Isle. Jacob Jackler, M.D., Waterville, gave the viewpoint of the doctor.

Left: Officers re-elected for the coming year at the annual meeting, Maine Hospital Association, are (l. to r.): Matthew I. Barron, administrator, Portland City Hospital, secretary; Lawrence M. MacDougall, Eastern Maine General Hospital, Bangor, president-elect; Neil H. Bunker, administrator, Mount Desert Island Hospital, Bar Harbor, president, and Sister Mary Mercy, Mercy Hospital, Portland, treasurer.

Administrative Seminars Presented for NYC Catholic Hospitals

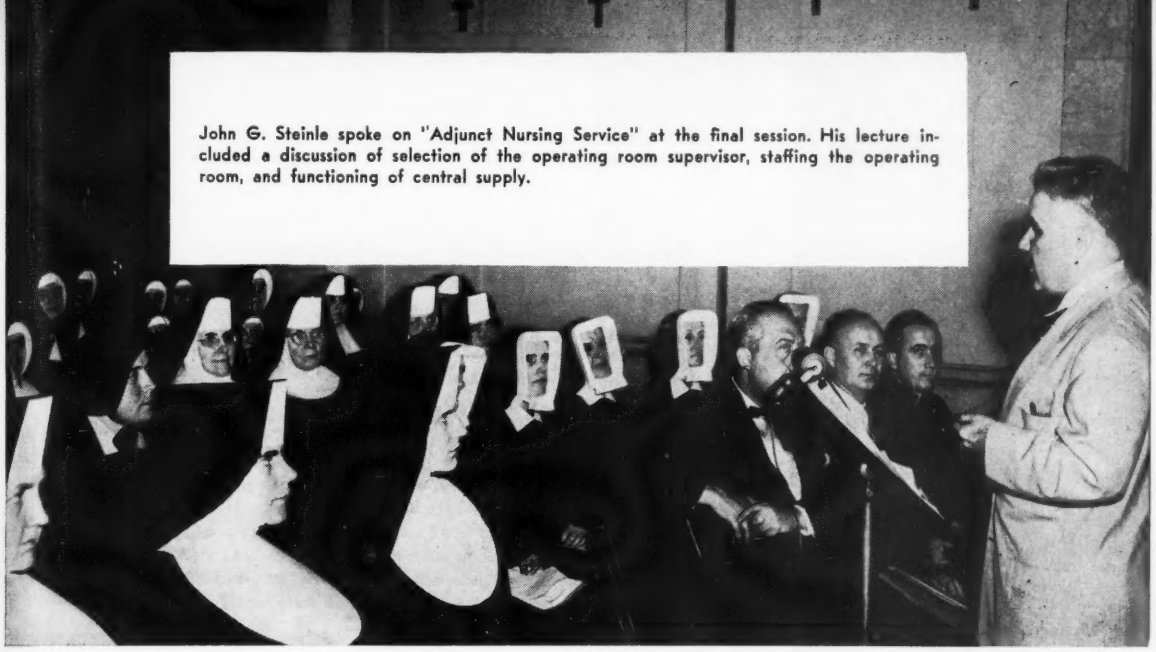


Above: Pictured during a coffee break are (l. to r.) Sister Mary Stella, hospital consultant, Tarrytown, N.Y.; Sister M. St. Joseph, central supply supervisor; Sister M. A. Kempis, medical records supervisor; Sister M. de Montfort, supervisor, outpatient department; and Sister M. Columcille, administrator, all of St. Clare's Hospital, New York City.

Above: This informal group in the entrance hall consisted of (l. to r.): Sister John Miriam, administrator's department, St. Agnes Hospital, White Plains, N. Y.: Sister Mary Madeline, administrator, Sister John Denise, x-ray superintendent, and Sister Mary Ellenita, medical records librarian, all of St. Mary's Hospital, Orange, N. J.

Below (l. to r.): Sister Mary Angela, Sister Superior, Sister Mary Elizabeth, procuratrix, and Sister Mary Andrew, pharmacist, all from Rosary Hill Home, Hawthorne, N. Y.

Above: Pictured in the foyer before entering the dining room are (l. to r.): Sister Mary Eleanor, administrator, All Souls Hospital, Morristown, N. J.; Sister Miriam Thomas, administrator, and Sister Marie Leo, business administrator, Good Samaritan Hospital, Suffern, N. Y.



John G. Steinle spoke on "Adjunct Nursing Service" at the final session. His lecture included a discussion of selection of the operating room supervisor, staffing the operating room, and functioning of central supply.

• Nineteen Catholic hospitals in the New York city area participated in 10 weekly seminars on hospital administration from April 21 through June 23, conducted by the consulting firm of Cresap, McCormick and Paget, under the auspices of New York Catholic Charities.

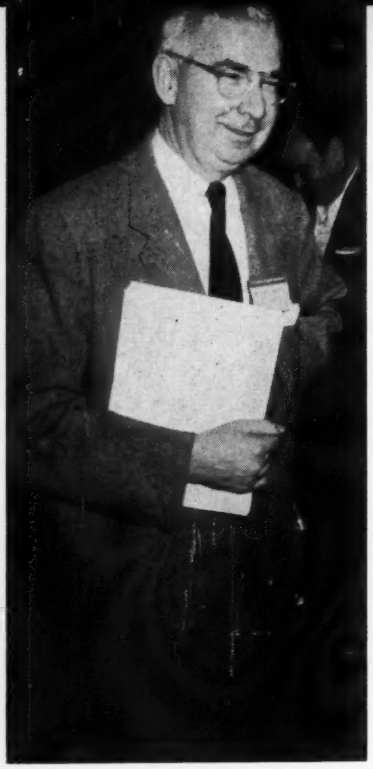
Topics covered in the seminar included: organization, personnel administration, business office, expenditure control, service departments, diagnostic services and nursing services. Eighty-five attended the sessions.

Pictures on these pages were taken at the final session on June 23, at which John G. Steinle spoke on nursing services.

Time for coffee break after a morning of busy sessions.

At left: Waiting for the elevator (l. to r.): Sister M. Josephine Eileen, administrator, St. Agnes Hospital, White Plains, N. Y.; Mother M. Assissium, Immaculate Conception Mother House, Hastings-on-the-Hudson, N. Y.; Sister John Miriam, administrator's department, St. Agnes Hospital, White Plains, N. Y., and Sister Mary Madeline, administrator, St. Mary's Hospital, Orange, N. J.

Members of the seminar faculty were all from Cresap, McCormick and Paget. Standing (l. to r.): F. C. Frantz, Earl J. Frederick, G. S. Conn, Vaughn Fry, H. J. Heneman, J. R. Collier. Seated (l. to r.): Joseph P. Kenny, Catholic Charities of N. Y., Archidiocese of N. Y.; John G. Steinle, and the Rev. Patrick J. Frawley, director, Division of Health and Hospitals of the Catholic Charities, Archdiocese of New York.



Above: Mr. Markey in a typical pose, at Catholic Hospital Association convention in St. Louis, 1955. His well-planned exhibits on purchasing were always popular features at CHA meetings.

Markey Educational Fund Established

• An educational fund for the five children of William H. Markey, Jr. who died June 30 in the TWA airline crash in Grand Canyon, has been established by the executive committee of the Catholic Hospital Association.

Mr. Markey was director of financial management services for the Catholic Hospital Association at the time of his death.

The fund will be set up for the immediate and long-range educational needs of the children.

Checks may be sent to the William H. Markey educational fund, Catholic Hospital Association, 1438 S. Grand Blvd., St. Louis.

Mr. Markey formerly was accounting specialist with the American Hospital Association. He helped prepare "Uniform Hospital Statistics and Classification of Accounts," Section I of the *Handbook on Accounting, Statistics and Business Office Procedures for Hospitals.*

After seven years as a public accountant he entered the hospital field in 1941 and served as manager, Hospital Council of Western Pennsylvania, and administrator, Shadyside Hospital, Pittsburgh.

Before joining the Catholic Hospital Association staff, he acted as private financial consultant to several organizations and hospitals.

A mass memorial service, one of the largest group funerals ever conducted, was held in Flagstaff, Ariz., July 9 for the 67 victims of the TWA airliner crash. Over 1,500 persons witnessed the procession of 50 funeral cars from a position at the rear of the pavilion, which housed 350 mourners. The photograph was taken at the close of the service before the portable crane lowered the caskets into the ground. Each casket, except the four for which military rites were conducted, held sprays of red and white carnations.

A lone pine tree marks the spots where the services were conducted by a Catholic priest, a Jewish rabbi, a Protestant minister, and an elder from the Church of Jesus Christ of the Latter Day Saints. The grounds will be known as the Grand Canyon Cemetery in the Flagstaff Citizens' Cemetery.

Care of The Tuberculous Patient in The General Hospital

By Eleanor E. Drummond, R.N.*

2. Above: The contents of the bag are: tissues, sputum cup with holder, hand lotion, and paper mask. The nurse teaches the patient immediately how to use these simple materials. The patient can do much to protect others. It is important to capture the patient's interest early and develop good nurse-patient rapport.

The paper mask is used by the patient during prolonged nursing care or when he is being transported to another area. The tissues are pinned to the bed for use to cover the nose and mouth when sneezing and coughing. The hand lotion contains 50% isopropyl alcohol and should be applied by the patient after he uses the tissues. It is tuberculocidal.

The paper bag is pinned to the mattress for easy disposal of used tissues and other such material.

3. Right: The nurse labels the room the patient occupies.

*Formerly tuberculosis nursing instructor, School of Nursing, Los Angeles County General Hospital. At present she is doing research on childhood tuberculosis for the Los Angeles County Tuberculosis and Health Association.

1. Above: The nurse receives the notification of the minifilm result within 24 hours after admission of the patient. She goes to the linen room and obtains a bag with necessary articles for immediate use in the isolation unit.

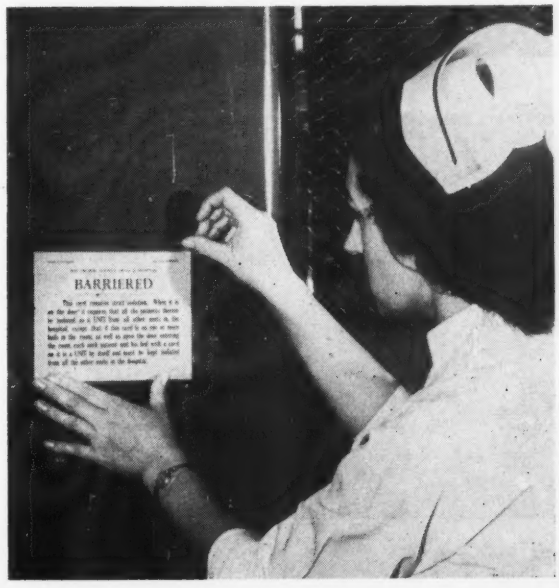
• Hospitals, large or small, specialized or general, at some time must care for the patient with active pulmonary tuberculosis. The true diagnosis of the patient may be unknown at the time of admission. The longer the unknown factor continues, the more the hazard to the hospital personnel increases.

Minifilm projects have contributed vitally to case-finding programs in hospitals. When the minifilm uncovers the case or suspected case, the challenge to nursing is evident.

Can the tuberculous patient be cared for in the general ward? Wherever the patient is located, are there safety measures for the personnel? Is the staff prepared to meet these precautions? Do they understand, and are they alert to a correct procedure? Is the staff prepared to minimize the emotional trauma the patient experiences

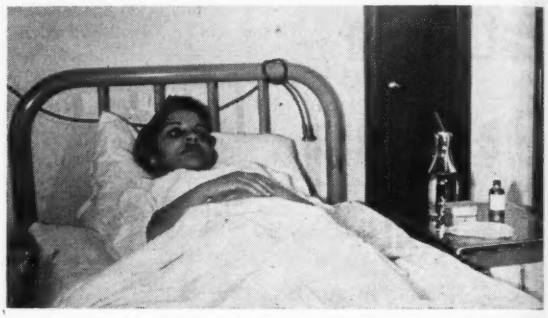
(Continued on page 36)

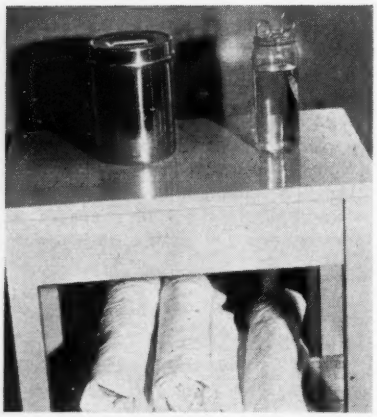
(Picture story continued on next page)



4. Above: The room should be private with toilet and running water whenever possible. On the table to the right are extra tissues, paper bags, newspapers, paper masks, sawdust for the sputum cup, and a thermometer. At the sink are paper towels, bar soap, orangewood stick, and hand lotion for the personnel. An uncluttered room is essential.

5. Below: Articles at the bedside help the patient protect others. The tissues and bag for disposal should be conveniently close to the patient. The hand lotion, sputum cup, and paper mask are on the bedside table.



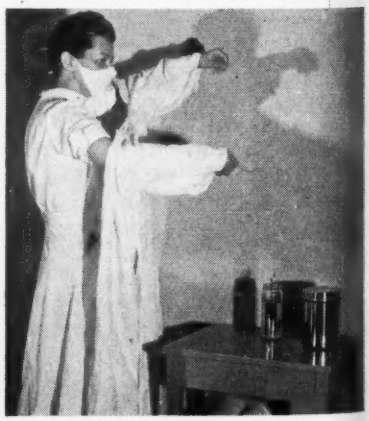


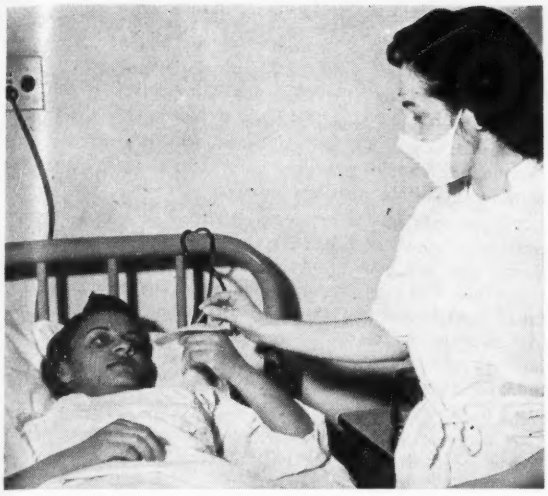
6. Left: The table outside the room is for the protective clothing used by the personnel. There are gowns, autoclaved gauze masks, and clean transfer forceps.

7. Right: The nurse washes her hands before putting on the protective clothing.

8. Left: She picks up the mask with forceps. The forceps are used as an extra precaution, to keep dirty hands from going into the can of clean masks, even though personnel are taught to wash hands before getting into the protective clothing.

9. Right: When the gown is put on, the waist strings are crossed in back and tied in front.





10. Above, left: The nurse wears protective clothing and a mask at the bedside for close and prolonged contact with the patient. They are not necessary for simply serving the diet or giving oral medications. Judgment must be developed among the staff. No procedure can answer all questions. The cover-all cap worn in some tuberculosis hospitals is not used at the Los Angeles County General Hospital as contact is not limited to tuberculosis patients. The nursing cap is removed to simplify the donning of the gauze mask. 11. Above, right: In removing the gown, the waist strings are untied. Hands are washed, and then mask and gown are removed. Good handwashing is stressed, and this can only be done with soap and running water, *never in a hand basin. On the table are the articles to be removed from the patient's room and decontaminated. The hospital uses paper dishes on all wards; these are wrapped and placed in the paper bag. Solid waste food is also wrapped and placed in the bag. Liquid waste is poured down the toilet. The other contents are tissues and the wrapped sputum cup. Top of paper bag is twisted securely to prevent scattering the contents. Other articles are rinsed and ready to be autoclaved.

*For another hand-washing technic recommended for the prevention of cross-infection on wards, see "Scrubbing with pHisoderm as Applied to a Maternity Hospital," by Reid, Walter, and Buck, **Surgery, Gynecology and Obstetrics** 91: 537, 1950.—ED.

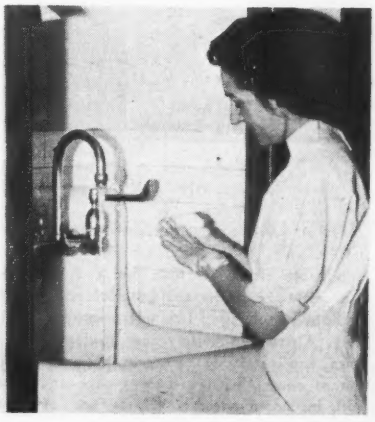
12. Left: Next step is disposing of gown and mask.

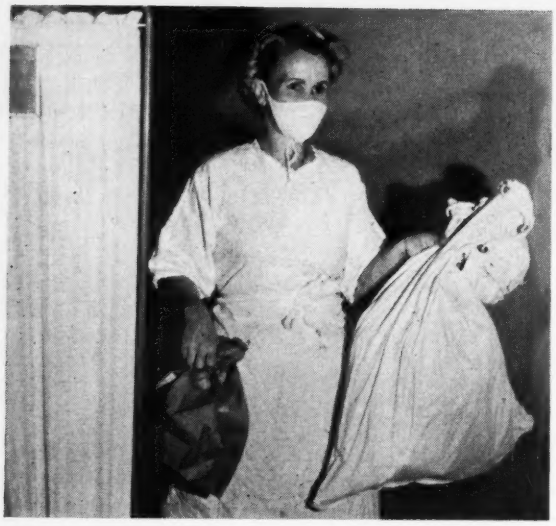
13. Right: She takes the articles to the autoclave in the ward treatment room. She uses a paper towel to open the door because her hands are not clean.

14. Below (l.): She disposes of expendable waste. Personnel are taught to dispose of articles in the safest and most expedient manner. Whatever can be burned is burned. Unexpendable items are exposed to terminal sterilization. (Saturated steam is available on every ward at Los Angeles County. Boiling water could be used if steam were not available.) Non-heat-stable articles not contaminated with blood or tissue fluid, are disinfected with 70% alcohol or 2% Amphyl.**

15. Right: She washes her hands again before going to other patients after handling the contaminated articles. Frequent handwashing is the cornerstone of good communicable disease technic and is enhanced by the repeated use of soap detergents containing hexachlorophene (G-11).

**Manufactured by Lehn & Fink.





16. In areas in which private rooms are not available, the patient is screened. This serves to remind the personnel and the patient that precautions are indicated. Patient education in protecting others is an effective way to limit the spread of bacteria. A minimum of six feet must be provided between patients. The nurse wears the gown out of the unit and disposes of the articles. She removes her gown in the approved manner at the closest running water, NEVER using a hand basin with already soiled contents. All laundry is handled as contaminated in the hospital, and an extra laundry bag is therefore considered unnecessary.

17. In the pediatric service the patient is too young to be taught to protect others. Also, for the patient's safety, nothing can be left at the bedside.

Other variations are necessary for jail wards and the psychopathic unit. It is important to consider basic principles of communicable disease technic first and then adapt them to the physical setting and current hospital policies. When a technic is developed or changed, prompt education of the total staff is necessary. Continued supervision is essential to provide good patient care and safety for all personnel. Good patient care of course means comprehensive nursing care and acceptance of the patient with his communicable disease and associated problems.

at diagnosis? Does the staff feel the responsibility for this patient? These are the principal questions that challenge the nursing staff in a general hospital when confronted with the care of the tuberculous patient.

The Los Angeles County General Hospital has met this challenge. What it has done may be applied to situations in other hospitals with the same good results.

All patients except acute emergencies receive a 70 mm. screening, chest x-ray on admission. (Emergency patients are x-rayed later.) Even patients who cannot stand are x-rayed as they remain on the specially provided stretchers. The minifilm functions around the clock and reveals the status of the new patient within a 24-hour period. When possible the patient with active pulmonary disease is transferred to the Tuberculosis Hospital on the grounds.

If the original condition which required hospitalization is the most pressing, the patient remains in the general hospital. While in the general hospital ward, he must be cared for with a practical and efficient isolation technic.

A simplification of the previous technic was necessary as an aid to preventing the fear the personnel often exhibit toward the care of the tuberculous patient. The patient has already experienced severe emotional trauma from learning his diagnosis. Therefore it is most important that the attitudes and actions of the personnel do not compound that trauma.

A committee of head nurses and instructors from representative areas was formed to develop the new technic. After outlining the procedure, considering the physical facilities and staff organization, the committee presented the first draft of the procedure to the monthly head nurses' meeting for suggestions. All the suggestions that were consistent with the basis principles of communicable disease technic were incorporated into the procedure.

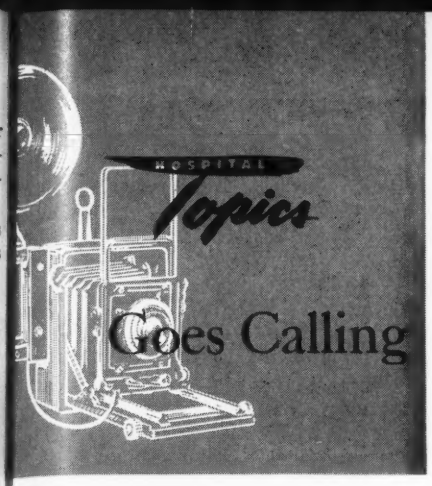
The committee then recommended to administration that this technic be used on all wards in the general hospital as the approved procedure for all hospital personnel. Approval was granted.

The next step was to print the procedure and add it to all nursing procedure manuals in the hospital. Since the nursing personnel number in the hundreds, plans had to be made to present the new technic in the quickest and most efficient manner. The chief nurse of the Tuberculosis Hospital suggested the value of a pictorial presentation for the new technic. With encouragement and funds from the health educator in the hospital and the local Tuberculosis and Health Association, pictures were made.

These were first shown to the supervising nurses of all services. Then meetings were held in the hospital auditorium for all nursing personnel. Each shift was scheduled to attend on duty time. The night shift had its program in the small hours of the morning. It was only three weeks before over 800 nursing personnel attended the hour-long program.

To begin the program, the Tuberculosis and Health Association film on "The Inside Story" was shown. This provided a good review for the personnel on what tuberculosis is, the basic treatments, and public health problems related to the disease. The technic was covered by showing the pictures and explaining each in relation to the four-page procedure now in the manual. Ample time was allowed for questions and clarification of details.

This entire project, from the beginning to the presentation of the finished procedure, was a completely cooperative experience between nursing service and nursing education.



. . . on W. Obed Poling,

Administrator

Broaddus Hospital

Philippi, W. Va.

• A unique work scholarship program provides well-trained part-time personnel for the Broaddus Hospital, Philippi, W. Va.

The 102-bed hospital, situated on the campus of the Alderson-Broaddus College (capacity about 300 students), utilizes over one-third of the college's student body, counting the student nurses enrolled in the only collegiate school of nursing in the state.

During the first semester last year there were 67 students working at the hospital and in the clinic—27 boys and 40 girls—and there were 53 student nurses. Five students were enrolled in the medical technology course and four in x-ray technology.

Students are assigned throughout the hospital and work eight-hour shifts (either 7-3, or 3-11; not 11-7) and alternate Sundays. They average 28 hours each every week, and guarantee 24. Two students provide the equivalent of one full-time employee.

They are paid an hourly rate, but they never handle the money they earn. Instead, the hospital writes one check to the college, covering wages earned by all the students, and the amounts are credited against the students' accounts. The program costs the hospital close to $100,000 a year, including stipends for student nurses.

Work scholarship students must keep a C average to stay in the program. The group has a lower drop-out rate than the student body as a whole.

A few boys are selected to receive special training to help with autopsies. Their pay scale is higher, because they are on call at night, and they must maintain a B average.

Holiday periods do not leave the hospital short-staffed, because program participants get only half the usual time off—one week out of two. Moreover, most of them work during summer vacations.

The college cooperates in scheduling work, by providing two class sessions for a subject when necessary. For example, freshman English is given on Monday, Wednesday, and Friday, and also on Tuesday, Thursday, and Saturday.

Below: Wayne Oldaker, junior education major, and Marion Batho, junior student nurse, put away supplies in operating room.

Below: Mrs. Alberta Greene, coordinator of college student work program, goes over problems with administrator Poling, in hospital cafeteria.

To be eligible for work scholarships, students must be needy, well-qualified, and in the upper half of their high-school graduating class. Usually they are in the upper one-fourth. They apply through the college registrar, usually before the end of their senior year in high school. Applicants are referred for interviewing to the program's coordinator, Mrs. Alberta Greene, who was formerly employed in the personnel department at Owens-Illinois Glass Co. Selection of applicants usually is completed by the end of April.

The students' training program, given during the summer before their freshman year, is a five-week course (equivalent to six, because school is held on Saturday too), which includes classwork plus on-the-job experience. Students are rotated through the various hospital departments—nursing service, housekeeping, and dietary. They spend one hour a day in a nursing arts course. They have a standard freshman orientation course, for which they get one hour college credit, and a course in anatomy and

(Continued on next page)

physiology (three hours credit). Instructors are all hospital staff members.

Whenever possible, students' requests are granted for work in specific departments. Once they are assigned to certain departments, they usually stay there.

Medical technology students may work only two years, because when they get into their specialized courses they usually need more time for study, and also their time is taken up during the day with full-time laboratory training.

Among the work scholarship students last year were four from outside the United States—one from Korea, two from the Philippines, and one from Japan—and two from other states. The rest were from West Virginia.

Students in the scholarship program receive no maintenance except uniform laundry, and no food—they eat at the college dining-hall.

Administrator W. Obed Poling says that the students make excellent employees. They are intelligent and aware of the need for good public relations. Patients become interested in the program when they learn that the maids and nurses' aides are students.

Above: Richard Crawford, medical photographer, shows gross specimen camera mounting that was made from old x-ray tube stand, with the assistance of maintenance engineer Ralph McDaniels.

Left: Mrs. Clementa Proudfoot, M. T. (ASCP), chief technologist, puts slips in student assignment box.

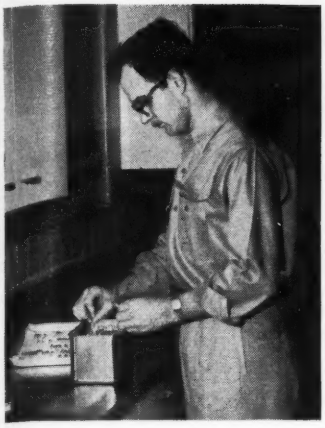
Below: Mrs. Louise Herod, acting dietitian (center), supervises as Mildred Aleshire (l), business administration student, and Dorene Moats (r.), elementary education major, set up trays.

The hospital has some other unusual features besides the work scholarship program. It is one of the smallest hospitals approved for a three-year residency program in general surgery. It has the first cobalt teletherapy machine in the state.

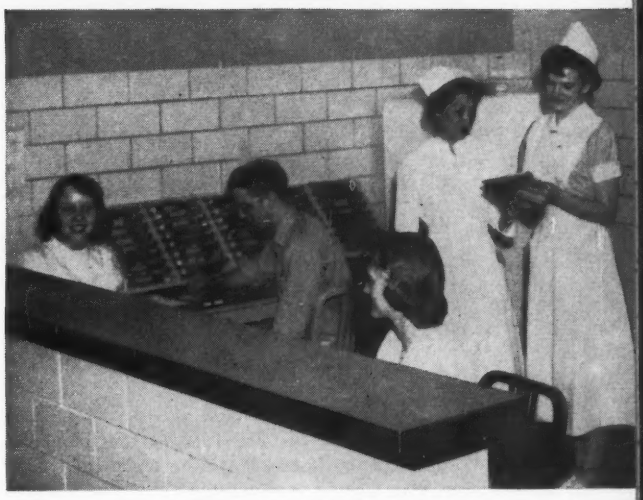
The $1,575,000 structure, built with the aid of $965,000 in Hill-Burton funds, opened two years ago this month. Actually it's a 106-bed hospital, but its library now occupies one four-bed ward. The money from the hospital's Ford Foundation grant will be used for building a library in conjunction with the college.

Outpatient clinic for the hospital is the Myers Clinic, a large, well-equipped medical clinic which also accommodated inpatients before the hospital opened. Ninety-five percent of the hospital's patients come through the clinic.

Philippi has a population of 2,500. Broaddus Hospital is on the site of the first land battle of the Civil War.



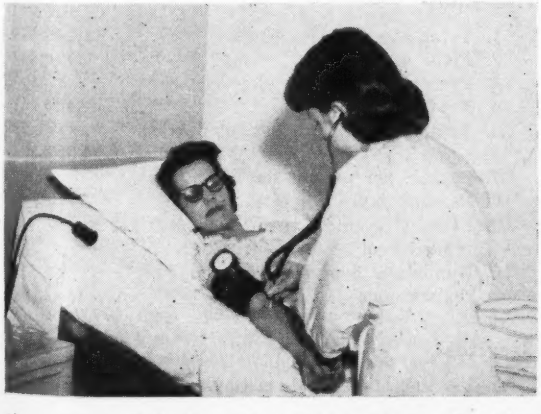
Left: Charlie Compton, senior music student, prepares needles and syringes for sterilization in central supply department.



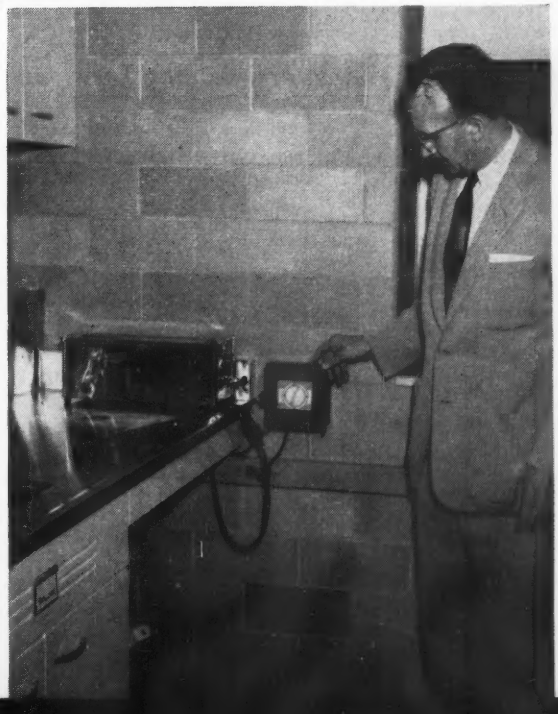
Above: At nursing station, Mrs. Chih-Wei Wu, clinical assistant professor in school of nursing, answers question of Lorena Miller, senior nursing student. Other students on duty at station are (l. to r.): Pat Martin, elementary education major; Jack Stemple, premedical student, and Norma Hanna, secretarial major.

Right: Raoul Ortigoza, Philippine Islands, housekeeping department employee and a sophomore in medical technology, cleans floor in front of admissions desk, at which are seated Barbara Teets (l.), x-ray technology student, and Annetta Cooper (r.), Christian education student.

Below: Inexpensive electric timer attached to sterilizer is a spring timer mounted by E. E. Myers, M.D., director of laboratories, on ordinary electrical junction box.



Above: Work scholarship student Patricia Martin takes blood pressure at patient's bedside.



Ready Reference of Hospital Facts

For Planning and Operation

Part VII

By Louis Block, Dr., P.H.

Long-Term General Hospitals in the United States

● From 1946 to 1954 the activities of the long-term general hospitals in the United States have changed. This is especially true when one notes the following changes that have occurred in the number of facilities available, their utilization, finances, and personnel. These hospitals now account for 5.8 percent of all hospitals, 4.5 percent of all beds, 4.5 percent of the average days of care provided, 0.7 percent of all admissions, and 3.6 percent of all expenses.

Facilities:

1. The number of hospitals has increased by 17 (from 389 to 406)—an increase of 4.4 percent.

2. The number of beds has decreased by 12,489 (from 83,415 to 70,926)—a decrease of 15.4 percent.

Utilization:

1. The average daily census has decreased by 1,937 (from 62,804 to 60,867)—a decrease of 3.1 percent.

2. The percentage of occupancy has increased from 75.3 percent to 85.8 percent.

3. The number of admissions has increased by 15,883 (from 139,332 to 155,215)—an increase of 11.4 percent.

Finances:

1. Total assets have increased $79,543,000 (from $342,932,000 to $422,475,000)—an increase of 23.2 percent.

2. Total expenses have increased $121,433,000 (from $68,149,000 to $189,582,000)—an increase of 17 percent.

3. Total expenses per patient day have increased $5.56 (from $2.97 to $8.53)—an increase of 187.2 percent.

4. Payroll expense has increased $87,488,000 (from $37,691,000 to $125,179,000)—an increase of 232.0 percent.

5. Payroll expense per patient day has increased $3.99 (from $1.64 to $5.63)—an increase of 243.3 percent.

Personnel:

1. The number of full-time personnel has increased by 18,294 (from 28,000 to 46,294)—an increase of 65.3 percent.

2. The number of full-time personnel per 100 patients has increased by 31 (from 45 to 76)—an increase of 68.9 percent.

The following presents some pertinent facts concerning the average long-term general hospital in the United States.

The Average Long-Term General Hospital in the United States*

Facilities:

1. Number of beds	175
2. Number of bassinets	2
3. Percent of hospitals with infant incubators	12.6
4. Number of incubators	2.1
5. Number of major operating rooms	1.4
6. Number of minor operating rooms	1.3

Utilization:

1. Number of annual adult admissions	382
2. Average daily adult census	150
3. Percentage occupancy	85.8
4. Average length of adult stay in days	143.1

Financial:

1. Total assets	$1,040,579
2. Plant assets	$770,857
3. Percent plant assets of total assets	74.1
4. Total annual expenses	$466,951
5. Total expenses per patient day	$8.53
6. Annual payroll	$308,323
7. Payroll per patient day	$5.63
8. Percent payroll of total expenses	66.0
9. Percent hospitals requiring funds for replacement	55.8
10. Number of $ per hospital required for replacement	$387,180

Services:

1. Percent of hospitals offering:	
a. Blood bank	13.7
b. Cancer clinic	5.4

* Based on information in American Hospital Association's Administrators Guide Issues (1951-1955)

c. Central supply room	32.2
d. Children's education program	38.2
e. Clinical laboratory	52.5
f. Dental department	47.5
g. Electrocardiograph	40.9
h. Electroencephalograph	7.5
i. Hospital auxiliary	34.0
j. Library, medical	40.9
k. Library, patient	63.0
l. Medical record department	62.4
m. Mental hygiene clinic	6.9
n. Metabolism apparatus	30.7
o. Occupational therapy department	54.6
p. Outpatient department	43.9
q. Pharmacy	34.6
r. Physical therapy department	59.4
s. Postoperative recovery room	15.5
t. Premature nursery	3.6
u. Radioactive isotopes	2.7
v. Rehabilitation department	30.7
w. Social service department	45.1
x. X-ray diagnosis	53.1
y. X-ray, routine chest, on admission	32.8
z. X-ray therapy service	10.4
aa. Organized training programs for auxiliary nursing personnel	9.2

Personnel:

1. Number of full-time personnel	114
2. Number of full-time personnel per 100 patients	76
3. **Nursing personnel:**	
a. Total graduate nursing personnel	22
(1) Administrative graduate nursing personnel	2
(2) Full-time instructors	0
(3) Supervisors and assistants	3
(4) Head nurses and assistants	5
(5) General duty nurses, full-time	9
(6) General duty nurses, part-time	2
(7) Nurses not classified	1
b. Private duty nurses	1
c. Practical nurses	23
d. Attendants	69
e. Nurses' aides	36
f. Ward maids	12
g. Orderlies	8
4. **Medical technologists:**	
a. Registered full-time	1
b. Registered part-time	0
c. Other full-time	3
d. Other part-time	0
5. **X-ray technicians:**	
a. Registered full-time	1
b. Registered part-time	0
c. Other full-time	1
d. Other part-time	0
6. **Occupational therapists:**	
a. Registered full-time	2
b. Registered part-time	0
c. Other full-time	1
d. Other part-time	0
7. **Physical therapists:**	
a. Registered full-time	3
b. Registered part-time	0
c. Other full-time	1
d. Other part-time	0
8. **Dietitians:**	
a. Full-time	2
b. Part-time	0
9. **Medical social workers:**	
a. Full-time	4
b. Part-time	0
10. **Pharmacists:**	
a. Full-time	1
b. Part-time	0
11. **Medical record librarians:**	
a. Registered full-time	0
b. Registered part-time	0
c. Other full-time	1
d. Other part-time	0
12. **Other medical record personnel:**	
a. Full-time	2
b. Part-time	0
13. Percent hospitals with retirement programs	41.3

— Departmental —

Governing board:

1. Number of members	14

Medical staff:

1. Percent hospitals with chief of staff	84.2
2. Percent hospitals with chiefs of services	49.5
3. Percent hospitals with written set of staff regulations	56.4
4. Percent hospitals with regularly scheduled meetings of staff	60.8
5. Percent hospitals with standing committees of the staff	39.5
6. Percent hospitals with executive committee of staff	30.8
7. Percent hospitals with medical record committe of staff	19.5
8. Percent hospitals with credentials committee of staff	16.7
9. Percent hospitals with tissue committee of staff	6.4
10. Percent hospitals with education committee of staff	11.8
11. Percent hospitals with pharmacy committee of staff	8.4

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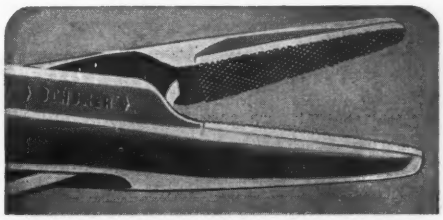

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12. Percent hospitals with dietary committee of staff 8.9
13. Percent hospitals with nursing committee of staff 14.5
14. Percent hospitals with other committees of staff 6.9
15. Number of staff physician appointments 33
16. Number of active staff 17
17. Number of active staff per 100 beds 9
18. Number of associate staff 3
19. Number of associate staff per 100 beds 2
20. Number of courtesy staff 3
21. Number of courtesy staff per 100 beds 2
22. Number of consultant staff 8
23. Number of consultant staff per 100 beds 4
24. Number of honorary staff 0
25. Number of honorary staff per 100 beds 0
26. Number of other staff appointments 1
27. Number of other staff appointments per 100 beds 1
28. Percent hospitals having psychiatrist on staff 55.8
29. Percent hospitals reporting surgical restrictions on staff 57.9
30. Percent hospitals permitting non-staff members to practice in hospital 33.9
31. Percent hospitals providing examining rooms for ambulatory patients of medical staff 15.9
32. Percent hospitals having private physicians' offices in hospital or on hospital grounds 4.9
33. Percent hospitals having x-ray facilities available to private ambulatory patients of staff 27.4
34. Percent hospitals having laboratory facilities available to private ambulatory patients of staff 24.9

Administrator:

1. Percent hospitals in which chief administrative officer is a physician 22.3
2. Percent hospitals in which chief administrative officer is a graduate nurse 36.4
3. Percent hospitals in which chief administrative officer is other than a physician or nurse 41.3
4. Percent hospitals in which chief administrative officer is a graduate of college course in hospital administration 10.9
5. Percent hospitals in which chief administrative officer is a male 49.3
6. Percent hospitals in which chief administrative officer is a female 50.7
7. Percent hospitals in which one or more persons perform full-time as assistant administrator 50.9
8. Percent hospitals having administrative staff member on duty at night 36.5
9. Percent hospitals delegating administrative responsibility to night supervising nurse 55.9

Laboratory:

1. Percent hospitals having physician staff members specializing in pathology 27.9
2. Percent hospitals having physician staff members specializing full-time in pathology 6.6
3. Percent hospitals having physician staff members specializing part-time in pathology 21.2
4. Percent hospitals having all tissue removed at surgery routinely examined by a pathologist 64.7
5. Percent hospitals having urinalysis on on all admissions 66.5
6. Percent hospitals having blood count on all admissions 52.8
7. Percent hospitals having serological examinations for syphilis on all adult admissions 39.1
8. Percent hospitals having electrocardiographs on all admissions over 45 years of age 9.6
9. Percent hospitals having Rh grouping on all pregnancy cases 8.9
10. Percent hospitals having preoperative blood groupings on all surgical cases 14.9
11. Percent hospitals having preoperative coagulation on all tonsillectomies 11.4
12. Percent hospitals having postoperative urinalysis on all surgical cases 14.9
13. Percent hospitals having no tests without doctors' orders 31.0

Radiology:

1. Percent hospitals having physician staff members specializing in radiology 29.9
2. Percent hospitals having physician staff members specializing full-time in radiology 5.4
3. Percent hospitals having physician staff members specializing part-time in radiology 24.4

Pharmacy:

1. Percent hospitals operating pharmacies 32.8
2. Of those hospitals operating pharmacies, percent having full-time licensed pharmacist 56.9
3. Of those hospitals operating pharmacies, average number of full-time pharmacists 1.5
4. Of those hospitals operating pharmacies, percent manufacturing parenteral solutions 10.8
5. Percent of hospitals having formulary 48.0

Outpatient Department:

1. Percent hospitals having one or more outpatient clinics 46.9
2. Number of annual clinic visits 7,412

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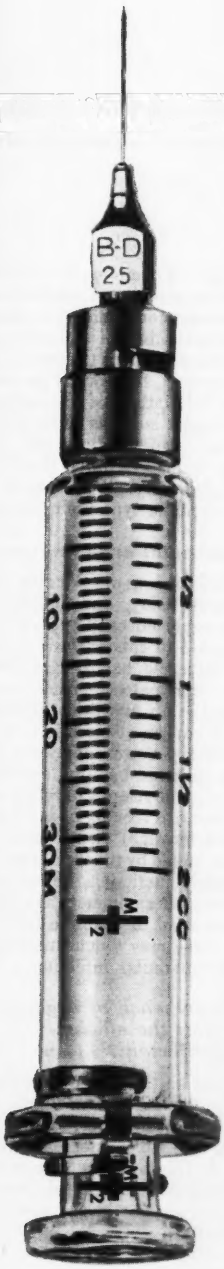

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"Nobody talks about it"...

but

is the incidence of cross infection getting to be a problem in your hospital — despite stringent aseptic technics?

Because of the basic nature of hospital service, keeping cross infection to a minimum has always been a difficult task. With antibiotics or other systemic antibacterials controlling the primary infection in most patients, reducing cross contamination may well depend upon making the total hospital environment as aseptic as possible. This, of course, is far from a new idea—but the prevalence of highly virulent, antibiotic-resistant organisms has accentuated the need for increased vigilance and control. Every hospital and physician knows the havoc that can be created by cross infection with antibiotic-resistant streptococci and staphylococci.

Whether infections are caused by contact with contaminated surfaces or objects, by breathing in dust containing viable organisms, or by contaminated dust settling on wounds—critical evaluation of both disinfection procedures and the disinfectant used may help solve the problem. For instance, regular mopping of all floors with a good disinfectant can remove the source of stirred-up contaminated dust.

How good does a disinfectant have to be?

It should approach the "ideal" as closely as possible. Most frequently mentioned requirements for the ideal disinfectant are that it be: microbicidal rather than inhibitory in use dilutions; not poisonous or irritating; rapid in action against a wide range of organisms; active in the presence of extraneous organic matter; not corrosive or staining; soluble in water; effective at ordinary temperatures; a good wetting agent; inexpensive; and stable for long periods of time.

Why is it important for a disinfectant to kill a wide range of organisms?

By definition, a disinfectant *is* a chemical substance which destroys all common pathogenic organisms. Some so-called disinfectants which do not kill all the commonly harmful microorganisms, including tubercle bacilli, are not actually fulfilling their purpose. For example, pine oil compounds are ineffective against staphylococci, while quaternary ammonium compounds are inactive against tubercle bacilli or pathogenic fungi. Enteric pathogens transmitted primarily by contact, respiratory pathogens spread by inhalation of contaminated dust, and fungi, such as those causing athlete's foot, can be destroyed at the same time using Lysol,® O-syl,® or Amphyl.® They are all-purpose, broad-spectrum phenolic type disinfectants.

Is tuberculocidal action necessary?

With 400,000 active TB cases in the United States today, and 100,000 new ones being reported each year, preventing the spread of tuberculosis is still a problem. Tubercle bacilli can live for weeks on inanimate surfaces and be stirred into the air and then inhaled. To control this source of infection, the disinfectant must penetrate the waxy covering of the tubercle bacillus and kill it. Lysol, O-syl, and Amphyl are all tuberculocidal and are recommended for concurrent and terminal disinfection of all premises occupied by tubercular patients. Tuberculocidal action is important for disinfection of thermometers as well as of instruments used to examine body cavities since these may touch unrecognized sources of tubercular infection.

Does the presence of organic matter affect the efficiency of the disinfectant?

It depends on the type of disinfectant. With Lehn & Fink disinfectants, which are synthetic phenolics, bactericidal, fungicidal and tuberculocidal efficiency is retained. Dilutions recommended for various applications of Lysol, O-syl, and Amphyl are for use in the presence of organic matter.

Is standardizing on one disinfectant of any advantage to the hospital?

Besides the extra assurance of knowing that the same efficient disinfectant is being used throughout the hospital, there is a financial saving possible through volume discounts.

Do Lysol, O-syl, and Amphyl do the same disinfecting job?

Any one of them kills bacteria, fungi, and TB bacilli efficiently, but each has individual characteristics.

Lysol was far ahead of its time when introduced over fifty years ago. Recently the formula was improved; the odor was lightened and toxicity was reduced so that the "poison" label is no longer needed. Many hospitals prefer Lysol because of its long reputation for dependability. The characteristic odor is preferred by many for psychological reasons or as an indication that disinfection with Lysol has just been done.

O-syl is preferred by hospitals wanting all the germicidal efficiency of Lysol but without the odor. It is practically odorless when diluted for use. Like Lysol, O-syl is highly concentrated. Only a 1% solution of either (1 part to 100 of water) is needed for most applications.

Amphyl is also odorless when diluted for use. Convenience and low cost due to its high concentration often make Amphyl the disinfectant of choice. Amphyl is twice as powerful as Lysol or O-syl but does not cost twice as much. A ½% solution (1 part in 200 of water) is sufficient for general disinfection so that the cost per gallon of "use dilution" is less than with Lysol or O-syl. When expected contamination is great, as in TB or isolation wards, Amphyl is often preferred.

Do you have special problems in disinfection?

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3. Number of annual private outpatient visits	4,395
4. Number of annual emergency visits	2,201

Medical Records:

1. Percent hospitals microfilming medical records	4.2
2. Number of annual deaths	73
3. Number of annual autopsies	15
4. Percent autopsies of deaths	20.9
5. Number of annual deaths released to legal authorities	24
6. Percent hospitals using Standard Nomenclature of Diseases and Operations	85.0

Admitting:

1. Percent hospitals using typewriter system for duplicating admitting records	62.8
2. Percent hospitals using mimeograph system for duplicating admitting records	1.7
3. Percent hospitals using liquid and gelatin system for duplicating admitting records	1.7
4. Percent hospitals using plate imprint system for duplicating admitting records	0.3
5. Percent hospitals using hand entry system for duplicating admitting records	21.7
6. Percent hospitals using other systems or combinations of above for duplicating admitting records	11.8
7. Percent hospitals routinely treating the following types of patients:	
a. Alcoholics	12.5
b. Cancer	46.1
c. Cardiac	58.3
d. Dermatologic	32.4
e. Drug addicts	5.7
f. Epileptic	23.2
g. Gynecologic	19.0
h. Isolation (contagion)	10.1
i. Leprosy	0.6
j. Medical	57.1
k. Mentally deficient	16.1
l. Neurologic	32.7
m. Obstetric	12.5
n. Ophthalmic	24.1
o. Orthopedic	59.8
p. Otorhinolaryngologic	20.2
q. Poliomyelitis	26.2
r. Psychiatric	14.3
s. Surgical	29.2
t. Tuberculosis	11.0
u. Urologic	33.3
v. Venereal disease	11.3
w. Acutely ill	30.0
x. Chronically ill	67.1
y. Students exclusively	0.0
z. Convalescent and rest	57.3
aa. Geriatric	47.6
bb. Industrial	6.1
cc. Pediatric	32.6
dd. Prisoners exclusively	1.4

Accounting:

1. Percent hospitals with ending date of fiscal year in —	
a. January	0
b. February	5.4
c. March	4.4
d. April	4.0
e. May	2.7
f. June	21.7
g. July	0.7
h. August	2.4
i. September	4.4
j. October	2.4
k. November	2.4
l. December	49.5
2. Percent hospitals which calculate depreciation	52.9
3. Percent hospitals which fund depreciation	26.5
4. Percent hospitals operating under formal budgets	72.5
5. Percent hospitals using AHA chart of accounts	28.4

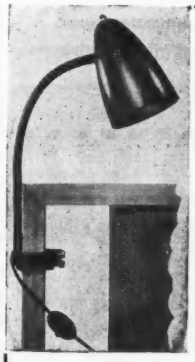
Purchasing:

1. Percent hospitals with central purchasing department	83.6
2. Percent hospitals with central purchasing departments with full-time purchasing agent	29.3
3. Percent hospitals with central purchasing department with part-time purchasing agent	55.8
4. Percent hospitals with central purchasing department with no reply as to purchasing agent	14.9

Public Relations:

1. Percent hospitals using booklet for employees	14.3
2. Percent hospitals using booklet for patients	18.0
3. Percent hospitals using regularly published house organ	4.4
4. Percent hospitals using printed annual report	15.2
5. Percent hospitals using patient opinion poll	6.5
6. Percent hospitals using personnel opinion poll	8.1
7. Percent hospitals using medical staff opinion poll	6.8
8. Percent hospitals using community opinion poll	0.7
9. Percent hospitals using none of these	85.7

(Continued on next page)



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Dietary:

1. Percent hospitals with dietitians	30.8
2. Percent hospitals with central food service layout	90.2
3. Percent hospitals with decentralized food service layout	9.8
4. Percent hospitals with selective menus for all patients	23.4
5. Percent hospitals with selective menus for private patients only	4.3
6. Percent hospitals not offering selective menus	72.3
7. Percent hospitals with manual and centralized dishwashing	24.5
8. Percent hospitals with manual and decentralized dishwashing	6.1
9. Percent hospitals with mechanical and centralized dishwashing	60.9
10. Percent hospitals with mechanical and decentralized dishwashing	13.6

Laundry:

1. Percent hospitals operating own laundry and processing all soiled linen	57.5
a. Number of pounds processed per week	13,359
b. Number of pounds processed per patient day	5.7
2. Percent hospitals operating own laundry and processing only a part of soiled linen	9.6
a. Number of pounds per week	1,310
b. Number of pounds per patient day	5.1
3. Percent of hospitals not operating own laundry	32.9
a. Number of pounds processed per week	3,122
b. Number of pounds processed per patient day	3.4

Auxiliaries:

1. Percent hospitals having organized auxiliaries	36.1

Safety:

1. Percent hospitals with organized safety committee	49.8
2. Percent hospitals with written fire emergency and evacuation plans	71.2
3. Percent hospitals with regularly scheduled fire drills	51.3
4. Percent hospitals having own written plan for mobilization of employees and medical staff	36.7
5. Percent hospitals whose written plan is integrated in master community plan	33.4
6. Percent hospitals represented on a community disaster planning committee	48.5

Religious:

1. Percent hospitals with a chapel	40.1
2. Percent hospitals with a meditation room for prayer	22.9
3. Percent hospitals with organized visiting clergy staff	40.0
4. Percent hospitals having chaplains available	83.6
5. Percent hospitals with full-time chaplains	17.0
6. Percent hospitals with part-time chaplains	20.4
7. Percent hospitals with chaplain on call only	44.7

HOSPITAL

Trends

BY LOUIS BLOCK, Dr. P. H.

Admissions
1934-1953*

Admissions to hospitals are a major item of measurement for computing hospital utilization. Knowledge of patterns of demand and use is imperative for proper planning of hospital services. Admissions reflect demand of the public for hospital services and its willingness to use these services; they indicate patterns of practice of the medical profession.

Because admissions are so radically different between long-term and short-term hospitals (hospitals in which the average patient stay is over 30 days and less than 30 days), it is best to look at them separately.

GENERAL AND SPECIAL HOSPITALS

Admissions to general and special hospitals skyrocketed during the period 1934-1953. In 1934 slightly over 6.7 million were admitted to this type of hospital; in 1953 the figure was almost 19.2 million—*an increase of 187 percent!*

Even more remarkable is the fact that only a part of this can be attributed to population increases. This is best illustrated when we compare the admission rates per 1,000 population during that period. Admissions per 1,000 population rose from 53.5 in 1934 to 123.0 in 1953. In other words, from an average population group of 1,000 people approximately 2½ times as many people were admitted to hospitals in 1953 than in 1934.

At the same time, actual available beds have increased only 67 percent. Either there is better utilization of hospital beds today and/or patients are not staying in hospitals for as long a period as they did in the past. It so happens that both situations are true.

In 1934 each general and special hospital bed was used, on the average, by 15 patients. By 1953 this average had risen to 28 patients. All this means is that more people actually and proportionately use the hospital today than formerly. This increased use of hospital beds far exceeds the rate of growth of available facilities. How can this growth—seemingly unrestrained on the one hand and slow on the other—be explained?

(Continued on next page)

*Based on hospital data in Annual Hospital Numbers of the **Journal of the American Medical Association**, and population data on Bureau of Census estimates, excluding armed forces overseas.

All evidence points to two developments which have had an unprecedented effect on hospital and medical care practices. These are: (1) advances in medical science, such as use of the antibiotics, early ambulation, and better methods of early diagnosis, and (2) an increased awareness and demand for hospital services by the public, resulting from widespread health educational practices and the tremendous developments in Blue Cross and other prepayment and compensation programs. The result has been an increased demand for and use of hospital services.

Translated into terms of measurable statistics, these developments are reflected in a decreasing average length of stay and an increased percentage of occupancy. In short, *proportionately more people are now being cared for with the same number of beds.*

NERVOUS AND MENTAL HOSPITALS

The pattern of admissions in nervous and mental hospitals, while not quite as dramatic as that of the general and special hospitals, still represents a substantial increase. From 1934 to 1953, admissions increased from 172,415 to 328,336, a growth of about 90 percent. Here too, the percentage of admissions was somewhat greater than the 46 percent in beds (513,845 to 749,393).

Proportionately more people are being cared for in nervous and mental hospitals than ever before. In 1934 admissions averaged 1.4 per 1,000 population. By 1953 this had increased to 2.1 per 1,000.

It is interesting to note that this increase of 50 percent in admissions per 1,000 population closely parallels the 46 percent increase in beds for the same period. This may well mean that little inroads have been made into answering the need in the mental hospital field. No sooner were beds made available than they were immediately utilized by an existing patient backlog. This fact highlights the tremendous need for a preventive mental health program.

And what about the needs and demands because of population increases since 1934? Obviously, these statistics alone do not supply us with all the information required to do an intelligent planning job for this important area of medical care. Much more must be known about needs, demands, and available facilities and their utilization.

TUBERCULOSIS HOSPITALS

Tuberculosis hospital admissions have shown the least increase, percentagewise, during the period 1934-1953. Compare the 32 percent increase (82,455 to 108,471) with the 187 percent in the general and special hospitals and with the 90 percent in the nervous and mental hospitals. The increase of tuberculosis beds during this period was likewise comparatively slight, 26 percent. Admissions per 1,000 population averaged 0.65 for 1934 and evidenced an almost imperceptible increase to 0.70 in 1953.

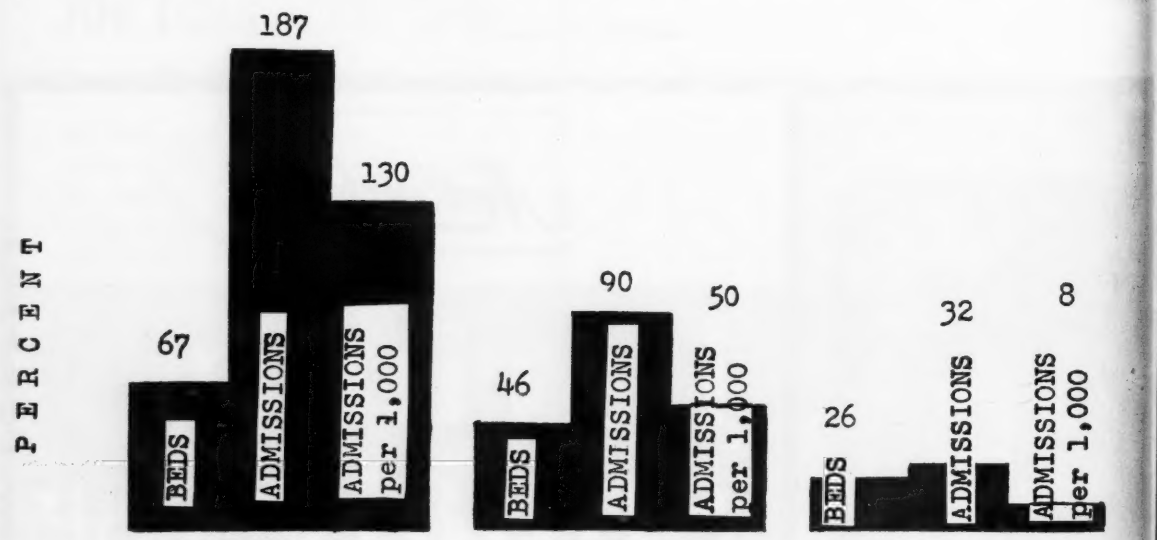
Whether this slower increase in the development of tuberculosis programs is a result of improper planning, an unbalanced emphasis, or is proper and just in light of relative proportion of needs met, requires further study and analysis.

SOME CONCLUSIONS

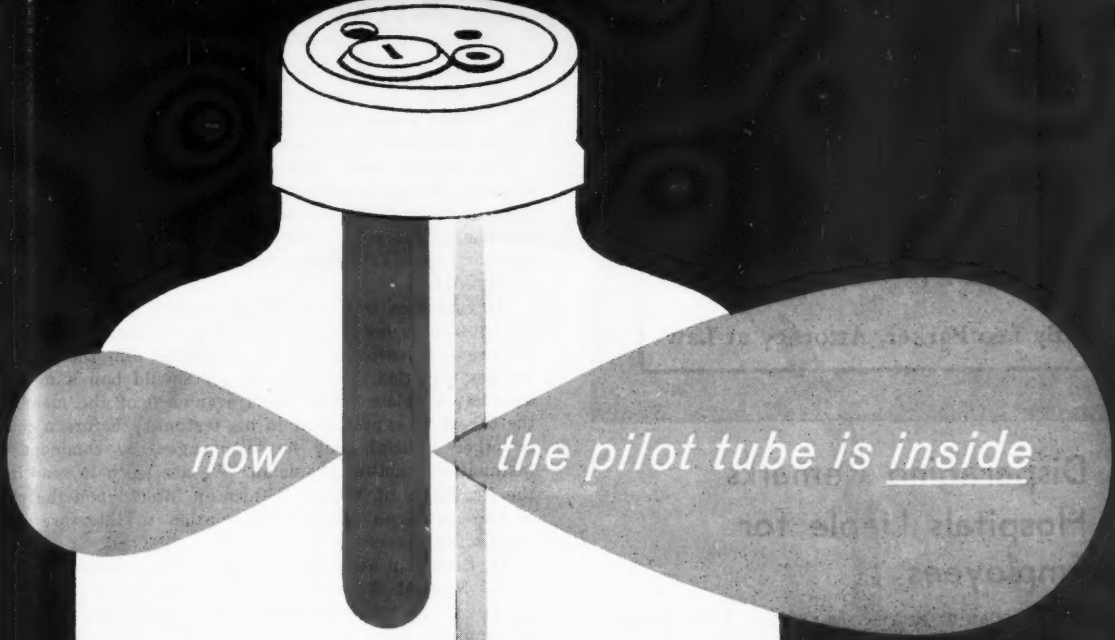
The above data emphasize the fact that more has been happening in the general and special hospitals than in any of the other types of hospitals providing specialized care in the past two decades. Not only are more people being admitted to general and special hospitals, but more beds are being provided in these hospitals.

It further appears that the proportionate need for services is being more rapidly met in the general hospital field than in the others. Although the former gaps in this area may well have justified the emphasis on this field in planning for the provision of hospital care, a re-examination of the progress made and the remaining needs that are to be filled in all areas is necessary in the near future. Such a re-examination is fundamental if effective planning of all areas is to be achieved.

PERCENT INCREASE IN BEDS, ADMISSIONS, ADMISSIONS PER 1,000 POPULATION BY TYPE OF HOSPITAL BETWEEN 1934 and 1953*



*Based on hospital data in Annual Hospital Numbers of the **Journal of the American Medical Association**, and population data on Bureau of Census estimates, excluding armed forces overseas.



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REVIEW OF HOSPITAL

LAW SUITS

By Leo Parker, Attorney at Law

• Disparaging Remarks
• Hospitals Liable for Employees

Can a physician or surgeon be expelled from a medical association because he violated certain bylaws of the association which prohibit disparaging or unfavorable comments regarding another physician or surgeon?

WHEN PHYSICIAN CAN BE EXPELLED

Recently a higher court clearly answered this question. Hence, I shall review the cause and outcome of this new higher court decision in considerable detail. Among other things this court held that no bylaw, rule, or regulation is valid and enforceable which is designed to prevent or prohibit a physician or surgeon from testifying or making a written report truthfully in judicial proceedings.

In Bernstein v. Alameda-Contra Costa Medical Association, 293 Pac. (2d) 863, the testimony showed that the Alameda-Contra Costa Medical Association had adopted bylaws which provide that a "member who violates any of the provisions of the Principles of Medical Ethics of the American Medical Association shall be liable to censure, suspension or expulsion."

Section 4 provides, among other things, that a physician in charge of a case should not disparage, by comment or insinuation, the physician who preceded him.

Dr. Ellis performed an autopsy upon the body of George Hill, who was injured under the State Workmen's Compensation Act, and gave the coroner a pathological report which said that Hill probably died of natural causes, although industrial injury might have been the cause. Later Dr. Bernstein was requested by the attorney for Hill's widow to prepare a pathological report.

Dr. Bernstein prepared this report, which was used by Hill's widow to obtain an allowance of compensation under the State Workmen's Compensation Act. The report was based upon a study of various papers, including the report of Dr. T. A. Miller, radiologist of St. Francis Hospital, the x-ray report issued by him, and the reports by Dr. Carl B. Eichorn, St. Francis Hospital, and the nurse on duty at the Columbia Steel Mill Hospital who first attended George Hill. Dr. Bernstein expressed the opinion that George Hill's death was caused directly by the injury. In setting forth in considerable detail the several factors which led him to that conclusion, he analyzed the autopsy report, which he deemed inadequate or erroneous.

Later the Alameda-Contra Costa Medical Association charged that Dr. Bernstein had violated the above-mentioned Section 4, because in his report he specifically described Dr. Ellis as a pathologist "who is not a certified pathologist, and who has rendered a very inexpert report" on the case. Also, Dr. Bernstein referred to Dr. Ellis as a "rather inept and inexpert individual." He further stated that "a more experienced pathologist would have examined the heart a little more thoroughly."

The higher court held that Dr. Bernstein had not violated Section 4 of the bylaws, and also held that a medical association's bylaw is void which holds over each member a threat of expulsion if he should disparage another physician, because it is against public policy. The court said:

"If witnesses were subject to slander and libel actions for utterances made in a judicial proceeding, the administration of justice would be hampered and the judicial process throttled. The same policy should ban a medical association bylaw which holds over each of the members the threat of expulsion if in his testimony before a court or other judicial body he 'disparages, by comment or insinuation' another physician. We are loath to read into the Principles of Medical Ethics an intent upon the part of the American Medical Association to interfere with the judicial process."

Dr. Bernstein also was charged by the Alameda-Contra Costa Medical Association with violation of Section 1 of its bylaws, which provides that a physician is subject to expulsion from the association if he does anything to diminish the trust reposed by the patient in his own physician.

Mrs. Leo F. Muir, a patient of Dr. M. L. Lipton, was in Pittsburg Community Hospital for delivery of her second child. It was decided that a Caesarean section was necessary, and the patient was moved from the labor room to surgery. Just prior to this removal, Dr. Bernstein, scrubbing for a delivery, spoke with a nurse within hearing distance of Mr. and Mrs. Muir. Dr. Bernstein commented to the nurse, and the comment was heard by Mr. and Mrs. Muir, that this was the poorest excuse for a section that he had ever seen and that "if she (Mrs. Muir) pushed one through, she can push another through."

The higher court held that Dr. Bernstein was guilty of violating Section 1 of the bylaws, and said:

"Appellant (Dr. Bernstein) claims that the remarks which he made to the nurse were not intended for the ears of Dr. Lipton's patient or her husband and that he was unaware that they did hear what he said. However, there was evidence that the doctor was only 12 feet distant from the patient and her husband and that the door between them was open. This canon in its application to the circumstances of the Muir case is neither unreasonable nor against public policy."

CITY HELD LIABLE

According to a late higher court decision, a city which owns and operates a hospital is liable for negligence of its employees.

In Swigerd v. City of Ortonville, 75 N.W. (2d) 217, testimony proved that a man named Swigerd suffered a cerebral hemorrhage and was admitted to the Ortonville Municipal Hospital, which is city-owned and operated. Swigerd developed a bedsore which required treatment with a heat lamp. He received burns in a fire which ignited during a heat-lamp treatment and burned a part of the mattress and sheet of the bed on which he was lying. Three days later he died. His widow sued the city for damages.

During the trial it was proved that Swigerd's burns resulted from the negligence of a nurse who had placed the lamp at the customary distance of about 30 inches from Swigerd's buttock for a 15 to 20-minute treatment. The lamp was placed too near the mattress on the bed.

One of the nurses, hearing a noise in Swigerd's room,

(Continued on page 62)

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Personally Speaking

New officers of the Alaska Hospital Association, elected in June at the territorial convention, Cordova, Alaska, are (l. to r.): the Rev. Howard E. May, Jr., administrator, Cordova Community Hospital, president; Mrs. Jane Igou, hospital facilities consultant, Alaska Department of Health, alternate delegate to American Hospital Association; Paul Nelson, Seward Sanitarium, delegate to AHA; Sister St. Hilary, Griffin Memorial Hospital, secretary-treasurer; Ruth Murrell, superintendent, Seward General Hospital, trustee; Alfred E. Maffly, guest speaker, president of Association of Western Hospitals, and administrator, Herrick Memorial Hospital, Berkeley, Calif.; Sister John of the Cross, Providence Hospital, Anchorage, vice-president.

Amy Adams—has been appointed clinical instructor, Susan B. Allen Memorial Hospital, El Dorado, Kan. She was a former director, Asbury Hospital School of Nursing, Salina, Kan.

Above, John F. Cade (center), secretary, Blue Cross Association, Sydney, Australia, was honored at a luncheon given by the Blue Cross Commission in July at the Drake Hotel, Chicago. With him are Walter H. Adams (r.), Deputy Consul General of Great Britain, Chicago office, and Robert T. Evans (l.), chairman, Blue Cross Commission and executive director, Chicago Blue Cross Plan.

Edwin B. Augustin—has been appointed assistant administrator, Altoona (Pa.) Hospital.

Elizabeth Baethke — has been named administrator, Kewanee (Ill.) Public Hospital, succeeding **Mrs. Elbert Peterson.**

John L. Beckwith—has been appointed assistant administrator, Lawrence and Memorial Associated Hospitals, New London, Conn. He was formerly assistant administrator, Highland Hospital, Rochester, N.Y.

Edward A. Behrman—has joined the staff, Catholic Hospital Association, St. Louis, Mo. Formerly he was administrative assistant, St. Joseph's Hospital, Flint, Mich.

Ruth E. Benfield—has been named director of nurses, Canonsburg (Pa.) General Hospital, succeeding **Elizabeth V. Harper.** Formerly she was director of nurses, South Side Hospital, Pittsburgh, Pa.

Actor James Mason (seated) writes personal check to Hawthorne (Calif.) Hospital Campaign as William Daniels, administrator, and nurse Jennie Latour look on. The drive is to add a million-dollar wing to outmoded and understaffed Hawthorne Hospital.

Forrest Brower (l.), new administrative assistant, East Orange (N. J.) General Hospital, is congratulated by hospital director Edgar C. Hayhow, M.D., who is celebrating his 40th year as a hospital administrator this year.

Gray Bingham — administrator, Glenn General Hospital, Willows, Calif., has resigned.

W. J. Bishop—has been appointed business manager, Martin County Hospital, Stuart, Fla., succeeding **Charles A. Johnson,** who resigned. He was formerly administrator, Lee County Memorial Hospital, Bishopville, S.C.

James B. Black Jr., M.D.—has been appointed chief of consulting staff, Pine Camp Hospital, Richmond, Va.

Julia Bloomfield—has been named director of social service, Mount Zion Hospital, San Francisco, Calif. She succeeds **Mrs. Sarah Korn** who retired.

Bruce E. Bredeson — has been named administrator, Russell (Kan.) Municipal Hospital, succeeding **John W. Joy** who resigned to take another position. Bredeson was formerly with the University of Kansas Medical Center.

James Conte—has been named assistant administrator, Jacksonville (Ill.) State Hospital. He was formerly administrative assistant, East Moline (Ill.) State Hospital.

Harry D. Cranston Jr.—has been appointed assistant administrator, Alta Bates Community Hospital, Berkeley, Calif. He was formerly business manager at the hospital.

William H. Cruse — has been named administrator, Bella Vista Community Hospital, Los Angeles, Calif.

Harry S. Cutler—has been named administrator, Riley's Hospital, Meridian, Miss. He was formerly administrator, Montfort Jones Memorial Hospital, Kosciusko, Miss.

Montez M. Dean—has been appointed personnel officer, East Orange (N.J.) General Hospital. She was formerly personnel assistant, Walter Kidde & Co., Belleville, N.J.

James Lowden Dennis, M.D.—has been appointed medical director, Children's Hospital of the East Bay, Oakland, Calif. Formerly he was coordinator of resident instruction at the hospital.

Kent Dickinson — has been appointed assistant controller, College of Medical Evangelists, Loma Linda, Calif., succeeding **J. H. Nies**, deceased.

Jessie Lee Dodson—has been appointed dietitian, Kansas Treatment Center for Children, Topeka, Kan. She was formerly assistant therapeutic dietitian, Wesley Hospital, Wichita, Kan.

Jean Doty, R.N.—has been appointed director of nursing service, North Platte (Neb.) Memorial Hospital.

Harry O. Dudley—has been appointed administrator, Winter Park (Fla.) Memorial Hospital. He was formerly administrator, Bourbon County Hospital, Paris, Ky.

Lawrence J. Dutel — has been named assistant administrator, University Hospital and Hillman Clinic, University of Alabama Medical Center, Birmingham, Ala.

Mrs. Jeanette Edlund, R.N.—has been appointed superintendent, Skagit General Hospital, Mount Vernon, Wash., succeeding **Mrs. Dorothy Ross** who will open a company hospital for Bagdad (Ariz.) Copper Co.

J. M. Edwards — has been appointed administrator, Leeds (Ala.) Hospital, succeeding **John H. Hargon**, deceased. He was formerly director, Emanuel County Hospital, Swainsboro, Ga.

Roy Edwards, M.D.—superintendent, Western State Hospital, Hopkinsville, Ky., has resigned.

Mrs. Ovanda Emmert—has been appointed administrator, Silverton (Ore.) Hospital. Formerly she was director, nursing service, Dallas (Ore.) General Hospital.

Lannie Enfinger—has been named head, dietary department, South Florida Baptist Hospital, Plant City, Fla., succeeding **Marietta Worthen.**

Carolyn Evans — has been appointed director, school of nursing, Matty Hersee Hospital, Meridian, Miss. Formerly she was on the faculty, University of Mississippi Department of Nursing, and with Rush Memorial Hospital, Meridian, Miss.

Paul Flanagan — has been appointed administrator, King's Daughters' Hospital, Staunton, Va. He was formerly assistant administrator, Middletown (Ohio) Hospital.

Ruth Fleck—has been appointed social service director, Saint Francis Memorial Hospital, San Francisco, Calif. She succeeds **Mrs. Helen Barret**, who resigned to study law.

Arthur C. Forche—has been appointed superintendent, Beyer Memorial Hospital, Ypsilanti, Mich., succeeding **Alfred Kurtz**, who resigned.

Robert E. Fore — has been appointed administrative associate, Baptist Memorial Hospital, Memphis, Tenn.

Thelma Garvin — has been appointed administrator, Tombstone (Ariz.) General Hospital.

Sidney G. Garrett — has been named administrator, Latter Day Saints Hospital, Logan, Utah, where he has been business manager.

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ADMINISTRATORS: (a) Medical; 250 bds; 12,000; if also qual assume County Phy post substantial increase; Calif. (b) Medical or non-med; impor hosp system; 15-$18,000; Pac NW. (c) Two units, 350 bds; attrac twn on ocean; W-Coast. (d) So. America; gen'l hosp operated under Amer auspices; one able reorganize all functions; knowledge of Spanish advantageous. (e) Vol gen hosp 125 bds; W. (f) JCAH hosp 100 bds; Mid S. (g) New gen hosp 100 bds; research cntr; Rocky Mtn area; (h) Gen'l hosp 100 bds to be erected; Eastern seaboard. (i) Vol gen hosp medium size; summer resort twn; Mich. (j) Gen vol hosp 100 bds; lge city; N.Y. state (k) Night Supt w/degree; full chge, tch'g hosp 700 bds; lge city; MW. (l) New post; male or female to serve as coordinator of med education; vol gen hosp, 500 bds; MW. (m) Ass't; tch'g hosp 800 bds; $7500; lge city, univ med cntr; MW. (n) Ass't; new gen hosp lge size; Bay area, Calif. (o) Ass't; vol gen hosp 800 bds; E. (p) Adm ass't; pub relations background; $7000; vol gen hosp 400 bds; E. (q) Adm ass't; 2 gen hosps, 550 bds; lge city; MW.

POSITIONS WANTED

ADMINISTRATORS: B.S. (Economics) M.B.A. (hosp adm); 3 years, accounting; (A.A.A.) 3 years, ass't comptroller, 500 bd hosp; (AAHA); 2 years, adm res & ass't dir, 750 bd hosp; presently, adm, 200 bd hosp; active in hosp affairs on state & local levels; exper'd man; Nominee, ACHA.
ADMINISTRATOR: M.H.A.; 3 years, ass't dir, 800 bd tch'g hosp; seeks hosp, 75-300 bds; any locality, exper'd man; Nominee, ACHA.
ANESTHESIOLOGIST: Diplomate; 6 years, priv pract, anes. & attend'g ones, 600 bed teaching hospital; any locality.
PATHOLOGIST: Diplomate, anatomy & clinical; FACP; sev years, ass't professor, path; 4 years, dir, dept path, large hosp.
RADIOLOGIST: Diplomate, diagnostic; Bd elig, therapy; 8 years, successful priv pract, dir depts & consultant, rad, several hosps; early 40's.

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William R. Howes — has been named administrator, St. Christopher's Hospital for Children, Philadelphia, Pa. He was formerly administrator, Evanston (Ill.) Community Hospital.

Robert Jensen — has been appointed superintendent, Thayer County Memorial Hospital, Neb., succeeding **Mrs. William H. Cholcher.**

George Adams — has been appointed assistant director, Methodist Hospital, Brooklyn, N.Y. He was formerly administrative assistant.

Carden M. Astin — has been appointed administrator, Chilton County Hospital, Clanton, Ala., succeeding **David W. Morgan.**

(Continued on page 55)

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Pictured above are new officers and members of the board of trustees, University of Illinois College of Pharmacy Alumni Association. **Back row:** (l. to r.) Ralph Tash, Joseph N. Pandolfo, Ralph D. Carpenter, Herbert Berry, and Rank Kozlicki. All are board members. **Front row** (l. to r.): Samuel Shkolnik, secretary; Reed G. Henninger, outgoing president; Milton G. Christy, vice president, Samuel A. Brody, president and George L. Webster, M.D., treasurer.

John P. Garrison—has been appointed assistant administrator of institutions, for hospitals and clinics of Alameda County (Calif.) institutions. He was formerly assistant superintendent, Highland-Alameda County Hospital, Oakland, Calif.

Rodney Lamb — has been appointed assistant administrator, Santa Barbara (Calif.) Cottage Hospital. He was formerly administrator, Cowell Memorial Hospital, Berkeley, Calif.

E. G. Logan—has been named director of personnel, St. Mary's Hospital, Tucson, Ariz. Formerly he was administrator, Tombstone (Ariz.) General Hospital.

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Ralph A. Lorini—has been appointed controller, Roosevelt Hospital, New York, N.Y.

Elmo H. Lund — has been appointed assistant administrator, Dr. W. H. Groves Latter Day Saints Hospital, Salt Lake City, Utah. He was formerly administrator, Latter Day Saints Hospital, Logan, Utah.

Florence Lynch—has been appointed executive housekeeper, Beth Israel Hospital, Boston, Mass.

Catherine MacDonald, R.N.—has retired as chief nurse, Georgia Street Receiving Hospital, Los Angeles, Calif., after 32 years of service.

Israel Magelaner, M.D.—has been named executive director, Jewish Hospital of Brooklyn, N.Y. Formerly he was medical superintendent, Kings County Hospital Center, Brooklyn, N.Y.

June Malone—has been appointed executive housekeeper, Muhlenberg Hospital, Plainfield, N.J. Formerly she was executive housekeeper, Beth Israel Hospital, Boston, Mass.

Elmer O. Massmann—has been named associate director, Stanford-Palo Alto (Calif.) Hospital. He was formerly administrator, French Hospital, San Francisco, Calif.

Harvey B. Matthews, M.D.—has been appointed education director, Norwalk (Conn.) Hospital. Formerly he was professor of clinical obstetrics and gynecology, Long Island (N.Y.) College of Medicine.

L. K. McMurtry, M.D.—has been appointed surgeon in charge, Wabash Employees' Hospital, Moberly, Mo. He was a former surgeon for the Veterans Administration.

(Continued on page 56)

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MEDICAL RECORD LIBRARIANS: (a) Chief. Middle East. Large hospital. Record dept. is well organized with a staff of 14. Present chief is retiring after nine years. (b) California. 100-bed hospital in town of 14,000. $4,800. (c) Chief. East. 100-bed hospital on Atlantic sea coast. Reg. not necessary. (d) Chief. Southeast. 250-bed hospital in winter resort area. $4,800. (e) Chief. Middle West. 200-bed hospital. 4 in dept. To $5,100. (f) Chief. Middle West. 250-bed hospital, to $6,000. (g) Chief. Middle East. Good exp. in supervision and thorough knowledge of Standard Nomenclature. 5 in dept. $5,300. (h) East. 350-bed, teaching hospital, nine in dept. $5,100.

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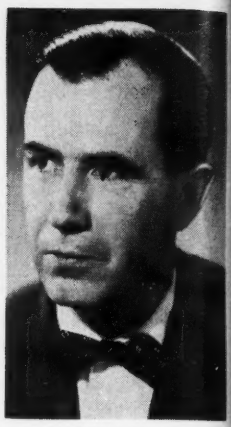

Shown above (l. to r.): James M. Kittleman, appointed director of resources and development of the newly-merged Presbyterian-St. Luke's Hospital, Chicago, Ill.; Norman A. Brady (currently administrator, Presbyterian Hospital), appointed assistant director, Presbyterian-St. Luke's; John A. Holbrook (assistant director, Presbyterian Hospital), appointed executive engineer, Presbyterian-St. Luke's.

PERSONALLY SPEAKING

(Continued from page 55)

Mrs. Lewis M. Miller—director, Rowan Memorial Hospital, Salisbury, N.C., for 25 years, has resigned.

John R. Moore—has been named administrator, Cowell Memorial Hospital, Berkeley, Calif. He was formerly administrator, Trinity General Hospital, Weaverville, Calif.

Mrs. Lucille Moorhead—assistant director of nurses, Western Pennsylvania Hospital, Pittsburgh, Pa., has resigned to study for a master's degree at the University of Pittsburgh, Pa.

Frank Muddle — has been appointed assistant administrator, Cleveland (Ohio) Clinic.

Raymond O. Muether, M.D.—has been elected president of medical staff, St. Mary's (Mo.) group of hospitals. Hospitals include St. Mary's, Firmin Desloge, Mount St. Rose, and Cardinal Glennon Memorial Hospital for Children.

Walter Noakes — administrator, Wewoka (Okla.) Memorial Hospital, has resigned to attend Oklahoma City (Okla.) University.

Constance Long O'Brien — has been appointed director, nursing services, City of Hope National Medical Center, Los Angeles, Calif., succeeding **Ida McCardle.**

Mildred F. O'Donnell—executive housekeeper, Mount Auburn Hospital, Cambridge, Mass., has resigned.

Warren A. Oliver — has been named administrator, Washington County Hospital, Plymouth, N.C., succeeding **R. M. Byrd.**

Richard L. Olsen—has been named assistant administrator, Presbyterian Hospital Center, Albuquerque, N.M. He succeeds **Stanley N. Allen,** who has been named clinic manager, Lemont-Peterson Clinic, Virginia, Minn.

Eugene Olszewski — has been named administrator, Rowley General Hospital, Mount Vernon, Wash., succeeding **Willis Parr.**

Willis E. Parr—has resigned as administrator, Rowley General Hospital, Mount Vernon, Wash., to become administrator, Skagit County (Wash.) Public Health District No. 1.

Thora K. Patterson—has been named director of nursing, University of Tennessee Memorial Hospital, Knoxville, Tenn. She was formerly director of nursing, Lincoln (Neb.) General Hospital.

Elmer W. Paul — has been appointed administrator, Burge Hospital, Springfield, Mo. Formerly he was superintendent, Flower Hospital, Toledo, Ohio.

Kenneth P. Payne, M.D. — has been appointed medical superintendent, Pine Camp Hospital, Richmond, Va. He was formerly director, acute and contagious disease ward, Army Hospital, Fort Eustis, Va.

William Peters — has been appointed assistant director, Methodist Hospital, Brooklyn, N.Y. He was formerly administrative assistant.

Grace Peterson, R.N.—has been appointed assistant director of nursing for patient relationships, Mt. Sinai Hospital, Chicago, Ill.

Verena Zeller Pettoruto, Col.—has retired as chief, U.S. Air Force Nurse Corps, Washington, D.C. She served 21 years.

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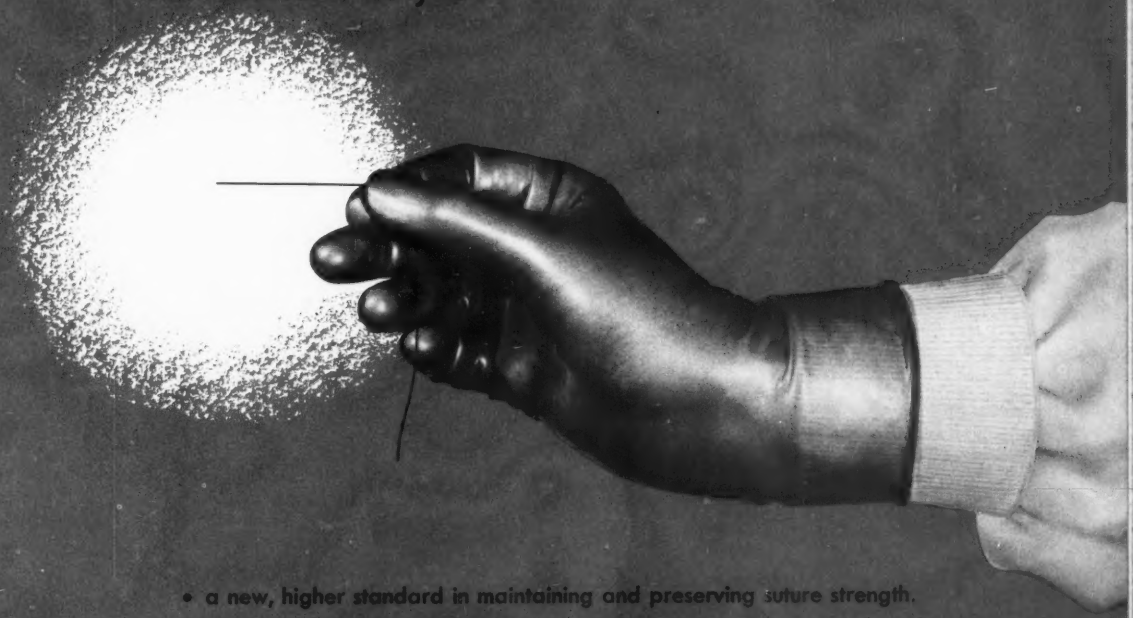

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Beatrice Phillips—has been named director, social service department, Beth Israel Hospital, Boston, Mass. She succeeds **Bess Dana.**

Mrs. Frankie J. Philpott, R.N.—has been appointed director of nursing service, Walker Memorial Sanitarium and Hospital, Avon Park, Fla.

Edna B. Pomeroy, R.N.—has been appointed administrator, Stephens Memorial Hospital, Norway, Maine. Formerly she was head, Frances E. Parker Memorial Home, New Brunswick, N.J.

Paul K. Potter—has been appointed administrator, Daviess County Hospital, Washington, Ind. He was formerly administrative assistant, Wesley Hospital, Wichita, Kan.

Walter F. Preset, D.D.—has been named administrator, Methodist Hospital and Home for Aged, Pittsburgh, Pa. He was formerly superintendent, Blairsville, Pa., district.

Donald Allen Rece — has been named administrative assistant, Mound Park Hospital, St. Petersburg, Fla. He was formerly administrator, Raiford Memorial Hospital, Franklin, Va.

Ruth A. Rees—has been appointed director of nursing service, White Cross Hospital, Columbus, Ohio.

Percy F. Riggs — has been appointed administrator, Hollywood (Calif.) Presbyterian Hospital-Olmsted Memorial, succeeding **Paul C. Elliott,** who was named executive vice-president and administrative consultant. Riggs was formerly assistant administrator.

Sanford Robinson—administrator, Winter Park (Fla.) Memorial Hospital, has announced his resignation.

Robert W. Rowland—has been appointed superintendent, Rouse Hospital, Warren, Pa. He succeeds **Richard C. Farver.**

Murray J. Rubin—has been appointed assistant administrator, Hunterdon Medical Center, Flemington, N.J., where he was formerly controller.

Sister Mary Salome—has been appointed, administrator, St. Elizabeth Hospital, Appleton, Wis. Formerly she was administrator, St. Andrew's Hospital, Murphysboro, Ill.

Peter Lindsay Scott—has been appointed administrator, North Shore Babies' Hospital, Salem, Mass. He was formerly assistant administrator, Lawrence and Memorial Associated Hospitals, New London, Conn.

Richard W. Sellers—has been appointed assistant administrator, Children's Memorial Hospital, Chicago, Ill.

Joseph Sherber — has been appointed administrative assistant, New York (N.Y.) Hospital.

Marie Serrill—has been appointed director of nursing service, Asbury Methodist Hospital, Minneapolis, Minn.

K. K. Sherwood, M.D.—has been appointed superintendent, King County Hospital System, Seattle, Wash., succeeding **Edwin S. Bennett, M.D.** who has retired. Formerly he was medical director.

Helen Shuford, R.N.—has been named administrator, Mission (Tex.) Municipal Hospital.

Sister Catherine Ellen—has been named administrator, St. Francis Hospital, Trenton, N.J., where she was assistant administrator. She succeeds **Sister M. Pierre.**

Sister Georgette Leduc—has been appointed administrator, St. Peter's Hospital, New Brunswick, N.J., succeeding **Sister Gilberte Baulne.** She was formerly director, school of nursing, and assistant administrator, St. Vincent's Hospital, Toledo, Ohio.

(Continued on page 59)

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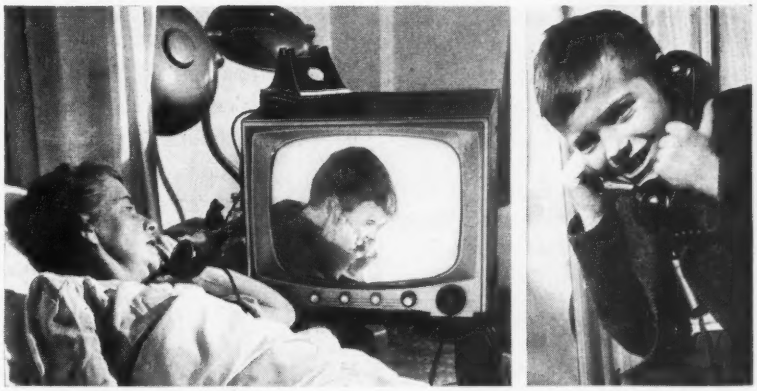

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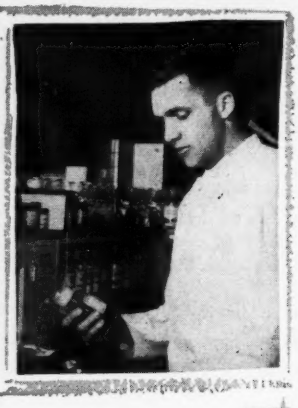

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PERSONALLY SPEAKING

(Continued from page 57)

Evelyn Sorenson—has announced her resignation as administrator, DeWitt (Ia.) Community Hospital.

Sister Luke of the Savior—has been named Superior, St. Vincent's Hospital, Portland, Ore., replacing **Sister Flora Mary.** She is succeeded as Superior, Providence Hospital, Portland, by **Sister Ruth Marie,** formerly Assistant Superior, St. Joseph's Hospital, Vancouver, Wash.

Sister Mary Philippa—has been appointed administrator, French Hospital, San Francisco, Calif. She was formerly administrator, St. Mary's Hospital, San Francisco, Calif.

Roy Stadler—has been named administrator, Ray County Memorial Hospital, Richmond, Mo.

Roy C. Stephenson—has been appointed administrator, Lowell (Mass.) General Hospital, succeeding **Paul J. Spencer.** He was formerly administrator, Idaho Falls (Idaho) Latter Day Saints Hospital.

Ladislav Stefan, M.D.—has been named director, pathological and clinical laboratories, Blessing Hospital, Quincy, Ill., replacing **Nicholas M. Alter, M. D.,** who resigned.

Jerome Gregory Stewart — has been appointed assistant administrator, The Staten Island (N.Y.) Hospital. He served his administrative residency, Long Island College Hospital, Brooklyn, N.Y.

Frank E. Stinchfield, M.D.—has been appointed director, orthopedic service, Presbyterian Hospital, New York, N.Y., and executive officer and professor of surgery, department of orthopedic surgery, College of Physicians and Surgeons, Columbia University, New York, N.Y.

William A. Stoppani—has been named administrator, Horatio N. Woodward Memorial Hospital, Sandwich, Ill., succeeding **Walter Schultz.** He was formerly administrative assistant, Danbury (Conn.) Hospital.

Elmer W. Stocker — has been appointed controller, Greenwich (Conn.) Hospital. Formerly he was with Jefferson Medical College, Philadelphia. He succeeds **John J. Dakin.**

John L. Sundberg — has been named administrator, Crenshaw Hospital, Los Angeles, Calif. He was formerly assistant administrator, Culver City (Calif.) Hospital, and succeeds **Charles S. Aston, Jr.,** who resigned.

James E. Tate, M.D.—has been appointed superintendent, East Louisiana State Hospital, Jackson, La., succeeding **E. M. Robards, M.D.,** who retired. Tate was formerly Lt. Col., Army Medical Corps.

John L. Towers Jr.—has been named administrative assistant, Baylor University Hospital, Dallas, Tex.

Horace Turner—has been designated administrator, Kadlec Hospital, Richland, Wash. He was formerly administrator, Deaconess Hospital, Spokane, Wash.

Carmela Valente—has resigned as night supervisor in obstetrics, Buffalo (N.Y.) General Hospital to accept a position with the Kenmore (N.Y.) Board of Education.

Harold W. Wade—has been appointed administrator, Atchison (Kan.) Hospital, succeeding **Robert Lyons,** who resigned. Formerly he was administrator, Clinton (Mo.) General Hospital.

C. D. Ward—administrator, Pitt County Memorial Hospital, Greenville, N.C., has been elected president, North Carolina Hospital Association. He is also president, Carolinas-Virginias Hospital Conference.

R. H. Ward—has been appointed administrator, Martin Memorial Hospital, Pell City, Ala.

Audrey Webster, R.N.—has been appointed superintendent, Gaylord (Minn.) Community Hospital, succeeding **Agnes Offerstein.**

Samuel Richard Wickel Jr.— has been appointed administrative assistant, Samuel Merritt Hospital, Oakland, Calif. He was formerly administrative resident, San Diego (Calif.) County General Hospital.

Ray L. Wine—has been named administrator, Deaconess Hospital, Freeport, Ill.

John M. Wood — has been appointed manager and administrator, Prairie du Chien (Wis.) General Hospital, succeeding **P. John Dunne,** deceased.

Mrs. Paula Woods — has been named director of nursing, South Florida Baptist Hospital, Plant City, Fla. She succeeds **Mrs. Evelyn Dye.**

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(Continued from page 59)

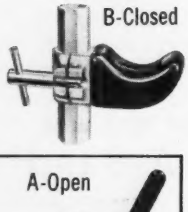
Deaths

Thomas Dyer Allen, M.D.—associate attending ophthalmologist, Presbyterian Hospital, Chicago, Ill., and clinical associate professor of ophthalmology, University of Illinois College of Medicine, died recently.

Wilfred E. Allyn, M.D.—79, former chief of pediatrics department, Huron Road Hospital, E. Cleveland, Ohio, died July 12.

Jean V. Cooke, M.D.—73, nationally known child specialist, died recently. Professor emeritus in pediatrics, Washington University School of Medicine, St. Louis, Mo., he had done pioneer work in immunization for tetanus, diphtheria, scarlet fever, and whooping cough in children.

A. Nowell Creadick, M.D.—clinical professor emeritus of obstetrics and gynecology, Yale University Medical School, New Haven, Conn., died July 23. He was a founder and three-time president, Connecticut Cancer Society.



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George G. Davis, M.D. — staff member, Provident Hospital, Anchorage, Alaska, died April 21. He was formerly on the staffs, Presbyterian and Cook County Hospitals, Chicago, Ill., and later was chief of staff, Alaska Railroad Base Hospital, Anchorage, Alaska.

P. John Dunne — administrator, Prairie du Chien (Wis.) General Hospital, died May 16.

Francis J. Gannon, M.D. — 47, staff member, St. Alexis and St. John's Hospitals, Cleveland, O., and Marymount Hospital, Garfield Heights, O., died July 9.

Mrs. Minnie Gorrell—76, former superintendent, Methodist Sanatorium, Albuquerque, N.M., died July 27.

Winfred Morgan Hartshorn, M.D.—82, former consulting physician in pediatrics, New York Polyclinic Hospital, died July 1. He had been associated with Roosevelt, Fifth Avenue and City Hospitals, New York, N.Y.

Elmer E. Highberger Jr., M.D.—51, former chief resident physician, Western Pennsylvania Hospital, Pittsburgh, Pa.; medical director, Grandview Sanatorium, Oil City, Pa.; and chief, internal medical staff, Westmoreland Hospital, Greensburg, Pa., died July 21.

Elihu Katz, M.D.—68, professor of gastroenterology, New York Polyclinic Hospital; director, department of gastroenterology, Seaview Hospital, Staten Island, N.Y.; and clinic professor of gastroenterology, Bronx (N.Y.) Municipal Hospital Center, died July 20. He was also consulting gastroenterologist, Bound Brook (N.J.) Hospital and Richmond Memorial Hospital, Staten Island, N.Y.

Fred Krug, M.D.—87, died July 15. He was on the staffs, Shriners Hospital for Crippled Children, Missouri Baptist Hospital and Incarnate Word Hospital, St. Louis, Mo.

Irving Leinwand, M.D.—45, died July 13. He had been associated with New York University, Bellevue and St. Clare's Hospitals, New York, N.Y.

Frank E. Mallon, M.D.—61, died June 24. He was a surgeon on the staff, Brooklyn (N.Y.) Eye and Ear Hospital, and consulting ophthalmologist, St. Mary's Hospital, Brooklyn, N.Y.

(Continued on page 87)

The Book Corner

Recovery Room

THE RECOVERY ROOM. By Max Sadove, M.D., and James Cross, M.D. Philadelphia: W. B. Saunders Co. 1956. 597 pp. $12.50.

This volume is the first of its type to be presented. The vast amount of information it contains will be valuable to all personnel actively engaged in the care of patients in the recovery room.

The need and purpose of a well-equipped recovery room, with specially trained personnel, is stressed.

Twenty-four authorities discuss, within the 21 well-illustrated chapters, the important data relative to the planning of a recovery room, plus medical and surgical care of a patient during the immediate post-operative period.

Since the efficiency of the nurses in a recovery room is to a great extent determined upon the physical arrangement of the room and its facilities, the authors point out, it is essential that personnel planning a recovery room seek advice and counsel in the planning stage.

The opening chapter concerning the advantages of an intensive therapy unit, the planning of such a unit and the formulation of policies and facilities will be of interest to the administrators.

Some other chapters deal with the management of shock, respiration, and nutrition, the care of patients in the recovery room following specific surgical procedures, and the management and care of medical problems in the recovery room.

Mental Planning

MENTAL PLANNING FOR SOCIAL ACTION. By George S. Stevenson, M.D., Sc.D. New York: McGraw-Hill Co., Inc. 1956. 358 pp. $6.50. The author examines the mental hospital and gives constructive suggestions to increase its contribution to mental health.

Knowledge of the goals of the mental health program, ways to find the mentally ill, and the need for classifying them are the cornerstone of a dynamic, constructive mental health program, the author declares.

Suggestions as to how the hospital may attract more personnel and utilize volunteer service to educate the public are included.

The place of government — county, state, federal — and the Veterans Administration is clearly shown, and an assessment is made of present and future contributions of the church, school, prison, military services, and other institutions.

This book offers many new perspectives to help those concerned with mental health to utilize existing facilities and work closely with others toward common goals.

Plant Maintenance Report

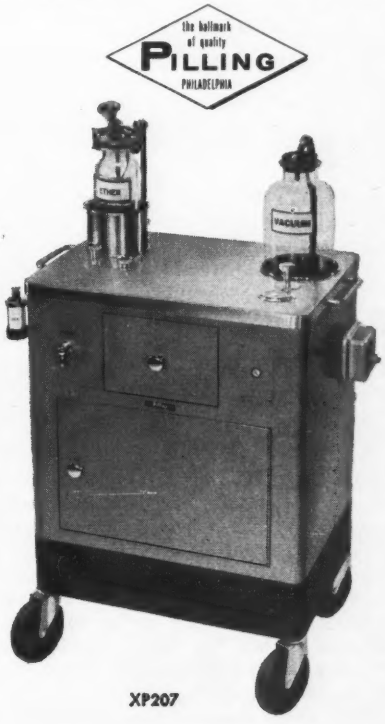
TECHNIQUES OF PLANT MAINTENANCE AND ENGINEERING— 1956. New York: Clapp & Poliak, Inc. 248 pp. $10. This year's book, seventh in a series, reports proceedings of the conference held with the Plant Maintenance and Engineering Show.

Sixteen papers, summaries of 15 roundtable discussions, and answers to approximately 1,100 specific questions are included.

Among subjects discussed are preventive maintenance, sanitation, equipment replacement policies, independent contractors, painting, design and operation of maintenance shops, cost control, inspection procedures, building and yard structure maintenance, use of punch cards, electrical equipment, lubrication, machine tools, relationship between maintenance and purchasing departments, utilities, forms and reports, and tool-room control.

RITTENHOUSE PUMP—for suction, pressure, ether

NEW O. R. MODEL
DOUBLE ROTARY UNIT
safer, more convenient to use



This double rotary unit is powered by a heavy duty ⅙ h.p. motor—plenty of power to operate the two separate compressors used to create positive and negative pressure. With this unit there is no possibility of cross contamination between suction and pressure.

SUCTION—the vacuum bottle is recessed in the top for greater convenience and safety; one gallon size insures adequate capacity for any operative procedure. The *amount of suction* is controlled by a regulating valve and is determined by a large and clearly visible vacuum gauge.

PRESSURE—the ether bottle is equipped with warm water jacket and regulator. One knob regulates *amount of pressure*, a second regulates *direction of pressure:* thru the ether bottle or thru front pressure nozzle. Pilling quick-detachable bottle top makes removal as simple and fast as turning a lever and loosening a thumb screw.

CABINET—functional and attractive • silver gray hammertone finish (special colors also available) • stainless steel top • 22″ wide, 16″ deep, 31″ high • large size casters, 5″ diameter.

UL LISTED for Class I, Group C, "hazardous locations" • automatic lubrication for rotary compressors included (occasional lubrication required for motor is easily accomplished) • compressor overflow traps are standard equipment • when writing for prices, specify current available (cycles and voltage)—standard model is 110 volts, 60 cycles AC.

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REVIEW OF LAW SUITS Continued from page 50

opened the door and found that the edge of the mattress and the bottom sheet were burning. The nurse who discovered the fire, assisted by a doctor, rolled Swigerd to the side of the bed to get him away from the fire. Twenty to 25 percent of Swigerd's body area was burned. These burns were not caused by the rays of the heat lamp but by the flames from the burning mattress and sheet.

In holding the city liable in damages to Swigerd's widow, the higher court said:

"The jury could accept as true the testimony of the plaintiff (Swigerd) that the lamp during the morning treatment was so close to the bed that a brown spot had been burned on the sheet and that the hospital nurses were then sufficiently warned of the danger to anticipate that a subsequent igniting of the bed clothes might occur. In the instant case the giving of the heat-lamp treatment obviously involved nothing more than an administrative act for which the hospital would be liable if negligently performed.

"The decision that the heat-lamp treatment should be given was a nonadministrative or medical act of Dr. J. F. Karn, the attending physician, but the execution, and the manner of implementing that decision, was merely administrative and did not call for specialized medical skill."

HOSPITAL vs. PHYSICIAN

Another important legal question is: "Is the hospital, which pays the nurse, or the physician, under whose direction the nurse acts, liable in damages to a patient who suffers injuries due to negligence of the nurse?"

First, it is well to consider the usual law that when a hospital assigns one of its nurses to perform a duty for a surgeon or physician, the latter automatically becomes responsible for negligence of the nurse, if the physician or surgeon directs the nurse what to do, and the patient's injuries are directly caused by failure of the nurse to carry out these orders which relate to specialized or technical matters, or services.

On the other hand, the courts hold that a hospital is liable for negligence of its nurse who injures a patient while performing ordinary or merely administrative acts or work, although at the time of the injury the nurse was under direct supervision of the patient's own physician or surgeon.

In Rice v. California Lutheran Hospital, 163 P. (2d) 860, the testimony showed that a doctor ordered that his patient be served tea. The negligent serving of the tea by the hospital nurse painfully burned the patient. The court held that the nurse's negligence was an administrative act for which the hospital was liable in damages.

Also, in Flower Hospital v. Hart, 78 Okl, 447, the court based liability of the hospital on the fact that the surgeon, following an operation, had ceased actual supervision and control over a nurse who placed an unshielded light bulb on the flesh of the patient and caused her to be burned.

Again, in Piedmont Hospital v. Anderson, 65 Ga. App. 491, it was shown that a doctor ordered an electric heating pad to be applied to the patient. In carrying out the order, the nurse applied the heating pad with the switch on hot instead of on low, which would have been proper. The patient was burned. The court held that in so doing she was acting as an employee of the hospital and that the hospital was responsible for her negligence, since she did not properly carry out the instructions of the patient's physician.

These cases illustrate "administrative" acts for which a hospital is liable for the negligence of its nurses and, by necessary implication, these cases carry with them a recognition that control remains with the hospital when its employees perform nonmedical acts. In this respect, the higher court held:

"Where no unusual features are involved which call for an exercise of medical skill or experience, a doctor may reasonably take for granted that the experienced nurses on the staff of a modern hospital will attend to their ordinary and customary duties without detailed instruction."

Thus the hospital, which employs a negligent nurse, is liable for her negligence in matters not strictly within scope of the field of specialized technic. Whether the assignment by the hospital of one of its nurses to the care of a patient involves a surrender of control to the attending physician, so that the hospital ceases to be responsible for the negligent acts of the nurse, can best be ascertained in the light of the recognized function of a modern hospital and the generally accepted limitations on a physician's time.

A physician can spend only a short time at the bedside of each patient and he must therefore leave the actual fulfillment of his prescribed treatment to others less skilled. If this were not the accepted practice, no person of moderate means could afford to employ either a specialist or a general practitioner.

A patient enters a hospital relying upon the reasonable assumption that its trained staff of nurses, its responsible supervision, and its special equipment will insure him a higher standard of care in administering to his needs as his physician may prescribe. If this assumption were not justifiable, the patient might just as well stay at home during his illness.

Clearly, a hospital has a greater responsibility for the welfare of its patients than merely to maintain a pool of trained nurses from which the various attending physicians may select their assistants. Many courts have increasingly recognized that a hospital has a responsibility for the exercise of reasonable care by a nurse while she is performing acts of a character which, though constituting a part of the patient's treatment as prescribed by the attending physician, do not require either the application or the understanding of the specialized technique possessed by a skilled physician or surgeon.

GIFTS OF BONDS UNLAWFUL

A reader asked this question: "Can a hospital or its employee always claim lawful ownership to government bonds donated by a patient?"

According to a leading higher court decision, a gift of certain kinds of government bonds is unlawful and illegal.

In Nelson v. Wheeler, 256 Pac. (2d) 1080, testimony showed that Alpheus Wheeler had been in and out of a hospital. He carried his belongings in a suitcase and handbag.

When he returned to the hospital suffering from a kidney disease, he handed an envelope to a hospital employee and said: "If I don't get well, this is for you." The envelope contained United States savings bonds, series E, all registered in his name. Soon afterward he died.

In subsequent litigation, the higher court held that the hospital employee could not claim ownership to the bonds, saying:

"Alpheus J. Wheeler, being the registered owner of the bonds, was the legal and equitable owner thereof at all times until the instant of his death. While gifts of other securities and property are recognized as valid in many instances under proper proof, the disposition of United States savings bonds must be administered under federal law. It follows, and we hold that United States savings bonds, series E, are not subject to gift."

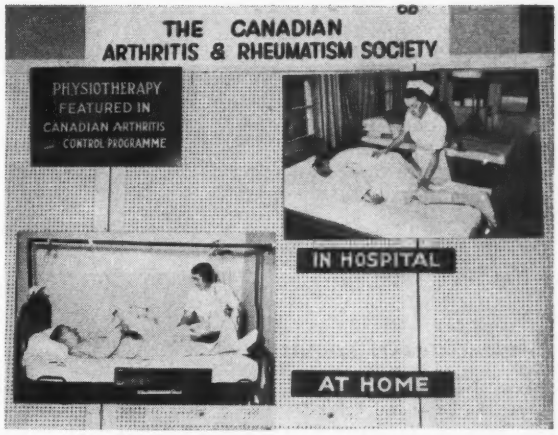
Special Picture Report

Second Congress

World Confederation for Physical Therapy

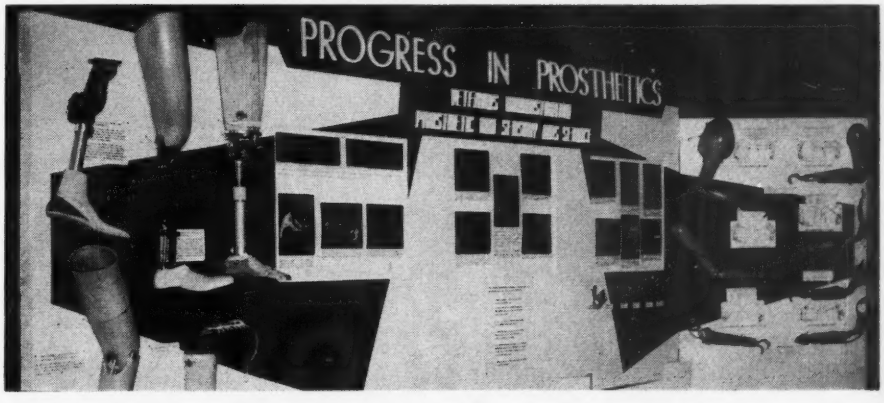
• Graphic displays featuring progress in physical therapy were featured in the scientific exhibits at the Second Congress, World Confederation for Physical Therapy, held in New York City June 17-23. Some of them are presented on this and the following pages.

For HOSPITAL TOPICS' detailed news report on the meeting, see the August issue, pages 12-14.



At right: Physical therapy home treatment program of the Canadian Arthritis & Rheumatism Society was featured in society's exhibit. Program is set up on a provincial level, and branches are established only with approval of local medical society. Therapist, on an average, will carry a case load of 30 to 50 patients and make six to eight treatment visits a day.

At right: Floating and stabilizing aids to be used with regular pool equipment to broaden the scope of pool therapy were featured in exhibit of Los Angeles Orthopaedic Hospital. With aids, patient can be treated on table, in upright weight-bearing position, or while partially freely floating.

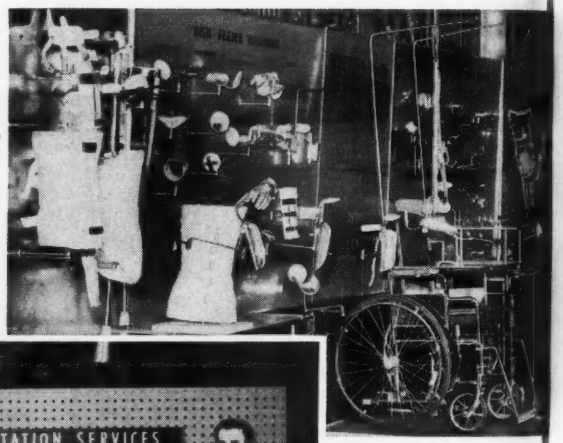


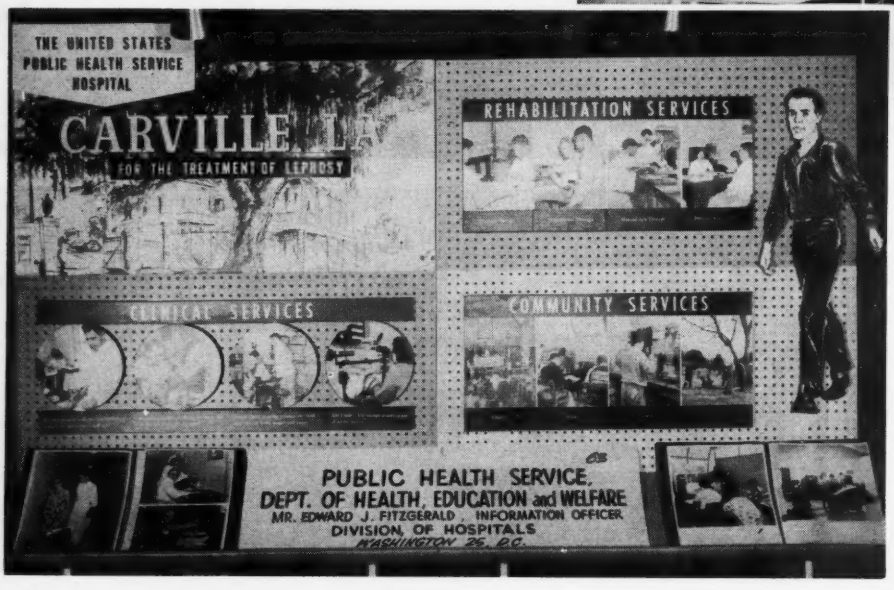
Latest developments in upper and lower extremity prosthetics were shown in VA's exhibit on "Progress in Prosthetics." Included were components available for artificial arms at different levels. Experimental models and technics were also displayed.

PHYSICAL THERAPY EXHIBITS Continued

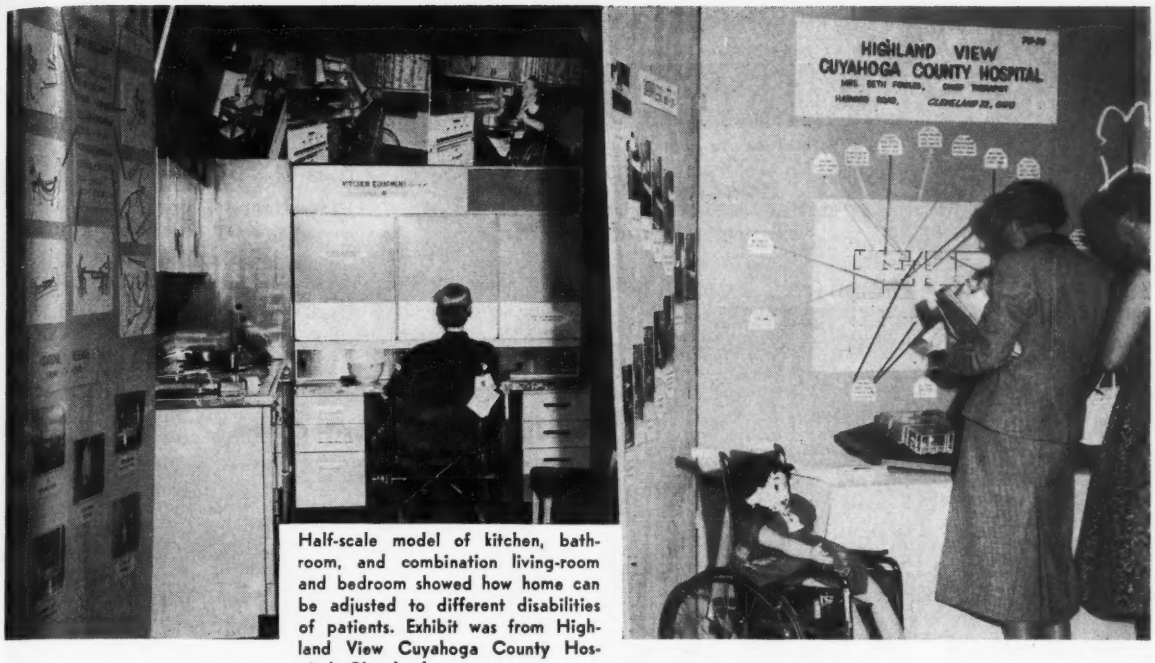
Above: Provisions for vocational rehabilitation of disabled civilians under the Vocational Rehabilitation Act were explained in exhibit of Office of Vocational Rehabilitation, Department of Health, Education, and Welfare, Washington, D.C.

At right: Exhibit on orthetics, presented by Georgia Warm Springs Foundation, showed various basic ortheses for the upper and lower extremities, basic "feeder" type ortheses, basic adapted ortheses, and ortheses for the trunk.





Public Health Service exhibit showed physical plant and facilities, clinical and rehabilitation services, and community activities comprising the program at the only hospital in this country devoted exclusively to care and treatment of patients with leprosy—at Carville, La.



Half-scale model of kitchen, bathroom, and combination living-room and bedroom showed how home can be adjusted to different disabilities of patients. Exhibit was from Highland View Cuyahoga County Hospital, Cleveland.

Exhibit on "Restitution of Function Following Hemiplegia" was presented by Army Medical Specialist Corps. Factors which influence recovery, according to exhibit, are selective reeducation, curtailed ambulation, nerve conduction blocks, and operative procedures. Three major impediments to recovery were listed as postural hyperactivity, dyssynergies, and proximal paresis.

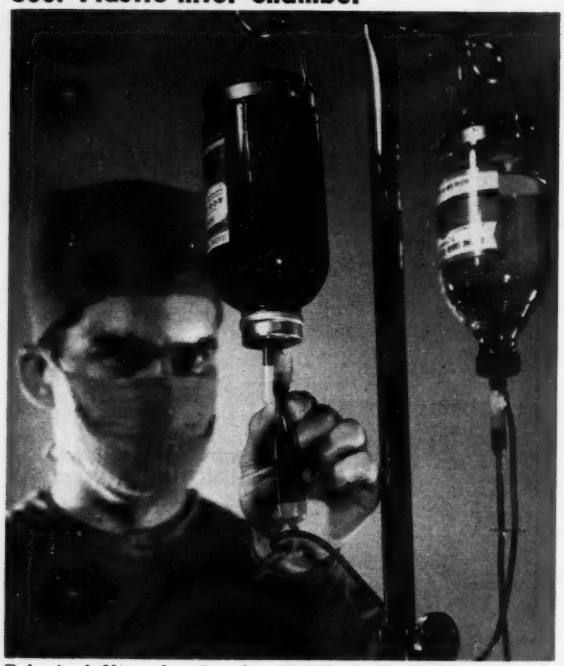
At right: Three panels of exhibit by Muscular Dystrophy Association showed: (1) what muscular dystrophy does; (2) the effects of the disease (presented in series of color slides), and (3) common forms of muscular dystrophy, onset, course and direction, and differential diagnosis.

BUYER'S GUIDE

Barbara Work
Buyer's Guide Editor

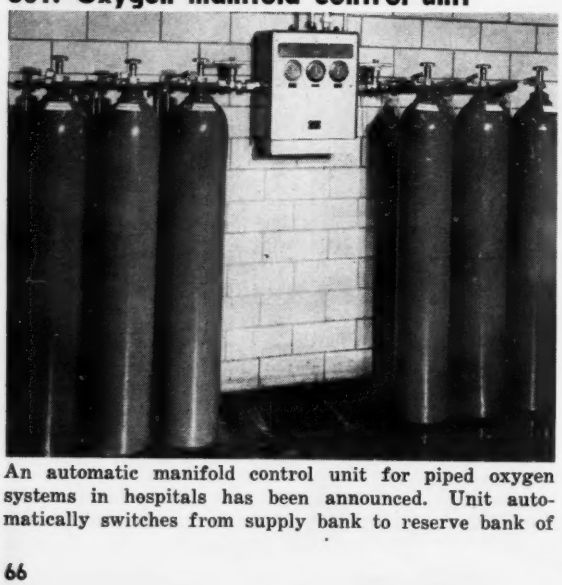
For further information on any of the products, please check the Buyer's Guide number on the reply card facing page 64.

300. Plastic filter chamber



Polyvinyl filter chamber fits directly under bottle of blood. Person administering blood can check on blood flow at a glance, because chamber is transparent. Light squeeze by attendant will prevent clogging. Chamber can be sterilized without harm because the polyvinyl material Geon is inert and noncontaminating. B. F. Goodrich Chemical Co.

301. Oxygen manifold control unit

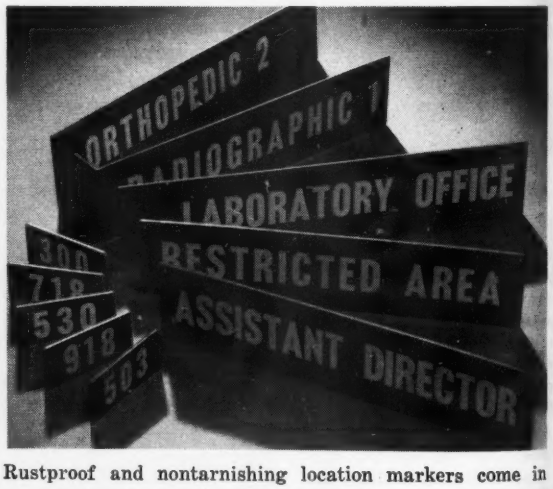


An automatic manifold control unit for piped oxygen systems in hospitals has been announced. Unit automatically switches from supply bank to reserve bank of cylinders when supply bank becomes exhausted. No manual action required except replacement of empty cylinders. No interruptions in gas service that might prove dangerous to patients. National Cylinder Gas Co.

302. Plastic-coated cup

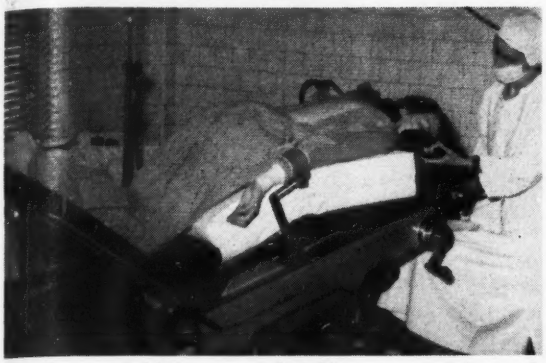
Special green-leaf design for hospitals in the China-Cote cup. The improved plastic coating preserves true flavor of coffee, tea, and other hot beverages. Creamer matches the cup. It has tight-fitting lid with inset tab that can be lifted with thumbnail. Lily-Tulip Cup Corp.

303. Location markers



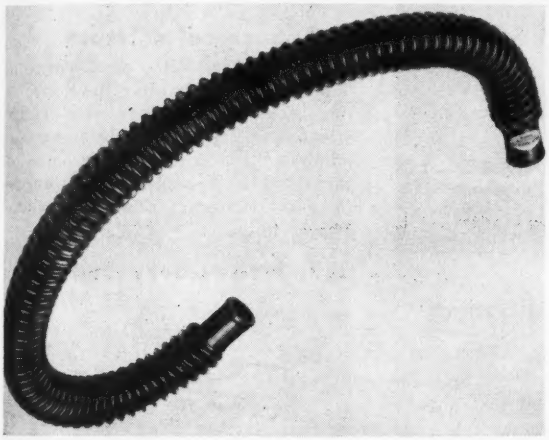
Rustproof and nontarnishing location markers come in gray butyrate plastic. Gothic lettering is hot-stamped in white to stand out against the darker background. Signs are molded in sizes to meet special needs of hospital, and in styles for mounting either parallel or at right angles to the wall. Wessco Products Co.

304. Prone position pad



Shoulders and hips are comfortably supported by pad, while center opening allows free respiration and minimizes abdominal compression. Pad has 3" of sponge rubber with a conductive, Koroseal cover for easy cleaning of well. Side aprons tuck under table to hold pad in position. Pad was developed to help during back operations when patient had difficulty in breathing because of pressure exerted on back by surgeon. Orthopedic Frame Co.

305. Inhaler tube



Heliciform design of Davol inhaler tubes materially reduces turbulence, lessens resistance, and makes possible more normal respiratory cycle. Tubes measure 34" in length, have ⅞" and 1" neck opening. Davol Rubber Co.

306. Felt tip pen

Pen will write on metal, paper, wood, glass, porcelain, cloth, plastics. Comes in range of from eight to ten colors. In hospitals pen can be used to mark uniforms, linen, and equipment of all kinds. Pen can be used for preoperative skin marking when it is filled with Flo-master skin marking ink. Cushman & Denison Mfg. Co.

307. Floor finish

"Style," a removable, buffable, polymeric floor finish, is intended for protecting and beautifying asphalt tile, linoleum, and sealed wood floors. Manufacturer says it has a superior resistance to dirt penetration. Vestal Laboratories, Inc.

308. Under-the-bed drawer

All-metal drawer can be attached under any bed. Has a drop hanger that can be used to attach the drawer and allow for up-and-down movement of hospital beds. Suntan shade is available for hospitals. Nash Mfg. Co.

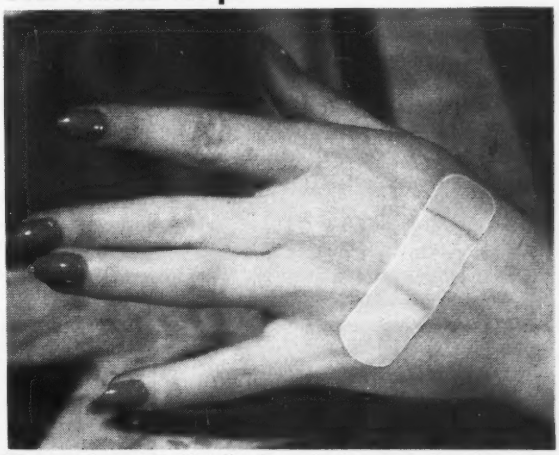
357. Dictation planning service

By using colored charts and stickers picturing dictation stations and clerical personnel, sales engineers can prepare a plan for the needs of any given institution. Under the system, a central recording unit serves one or more dictation stations located on different floors of the hospital. Gray Mfg. Co.

309. Noiseless typewriter

Remington noiseless comes in six colors; white sand, desert sage, mist green, French gray, honey beige, and lime light. Remington Rand.

310. Plastic strips



The number and distribution of air vents has been increased in Band-Aid plastic strips, patches and spots. Company says that it provides optimal aeration of both gauze pad and wound — speeds healing and minimizes maceration of skin. Rectangular ends of plastic strips have been replaced by rounded ends. Johnson & Johnson.

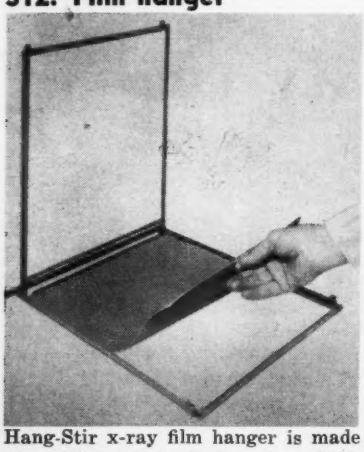
358. Plastic dinnerware

New molding technic makes it possible to color-band melamine plastic dinnerware. Dinnerware in Regal line is available in white with bands of burgundy, sage green, jonquil yellow, pastel blue, sea green, ocean coral, or stone gray; also tan with a band of sepia. Plastics Mfg. Co.

311. Portable anesthesia machine

Both Western Reserve portable anesthesia machine and cylinders are portable. Turn of wrist releases oxygen into rebreathing bag in matter of seconds. Total weight less than 2 lbs. Can be hung on wall of nurse's station. Unit is equipped to accommodate midget cylinders of cyclopropane in nonexplosive mixture and oxygen and helium. All rubber and metal parts are conductive. Continental Hospital Service Inc.

312. Film hanger



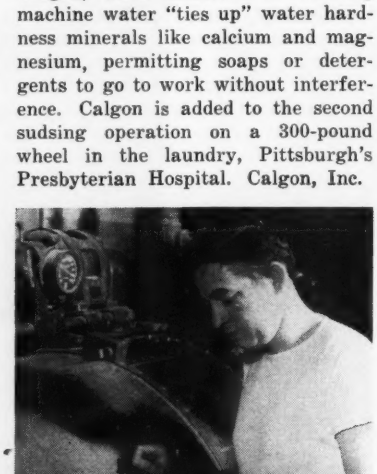
Hang-Stir x-ray film hanger is made of stainless steel. It has six rubber friction pads that are placed around angle frame into which another angle fits. This provides positive clamp that holds film in holder. Frame opens with slight thumb and finger pressure. Stirrup Metal Products Corp.

313. Cold steam humidification

By centrifugal force a water vapor is produced without heat. The moisture produced assures a speedier method of liquefying congestions, according to the manufacturer. Walton Laboratories.

314. Water-conditioning agent

Calgon, when dissolved in washing machine water "ties up" water hardness minerals like calcium and magnesium, permitting soaps or detergents to go to work without interference. Calgon is added to the second sudsing operation on a 300-pound wheel in the laundry, Pittsburgh's Presbyterian Hospital. Calgon, Inc.



315. Blood-collection set

Pliapak is used with a blood-collection set that can collect 450 cc. of blood by gravity. Pliapak consists of a disposable, non-wettable, pliant and tamper-proof plastic bag. It can be centrifuged in standard 500 cc. water-filled cup. Abbott Laboratories.

316. Surgical scissors

Alton Ochsner, M.D., chief surgeon, Tulane University, has developed a line of surgical scissors with Tungsten-Carbide cutting edges permanently built into the cutting blade of the scissors. Scissors are known as Ochsner Diamond Edge. Snowden-Pencer Corp.

317. Heavy-duty range

Heavy-duty range has a combination of five top cooking units plus sealed-heat oven base highlight. Top units are thermostatically controlled to maintain any of three available heats. Temperature range of 200° to 500°. Hotpoint Co.

318. Patient lift

Wheelchair-to-car transfer lift rests on suction cups. Is held in place by adjustable hooks that snap under drip eave. After installation, lift stays mounted on car. Ted Hoyer & Co.

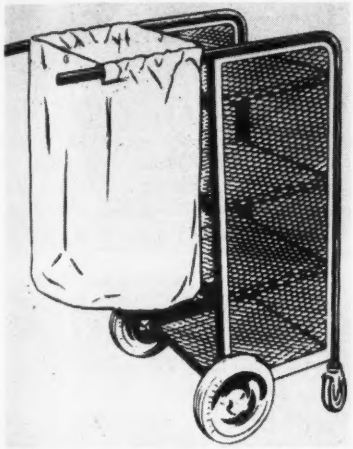
319. Sound projector

Pageant sound projector permits addition of background music and narration to medical education and hospital training films without special equipment or sound studios. Projector combines principles of tape recorder and movie projector into one compact portable unit. Hospital can make 16 mm. film, have magnetic stripping added, and record narration in hospital. Eastman Kodak Co.

320. Hypoallergenic fruit juice

BiB is specially processed orange juice for babies and growing children. dren. Each four ounces guarantees more than baby's daily requirements natural vitamin C. BiB Corp.

321. Linen truck



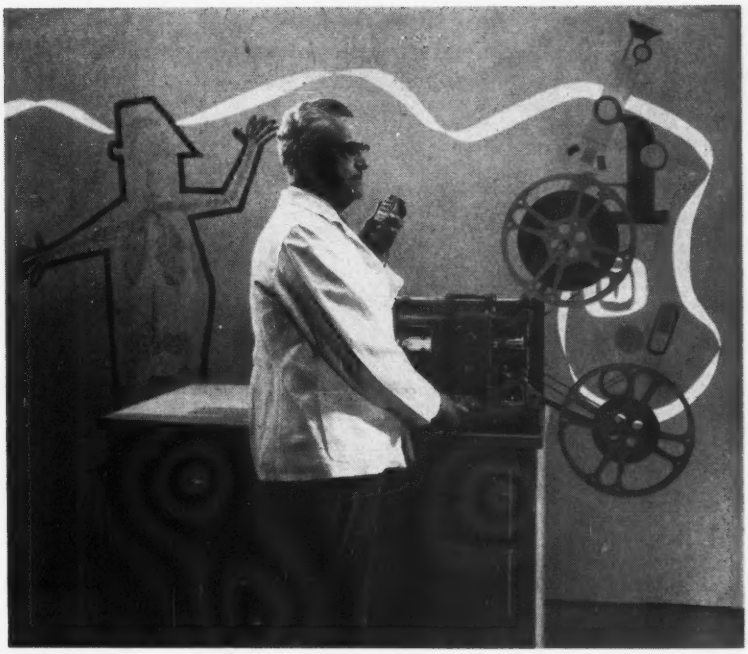
Linen truck designed to give plenty of supply space for efficient handling of maid, porter, and janitor work. Truck is welded into single unit to give solid strength and easy push movement. Truck is 50″ long x 22″ wide x 42″ high. The shelves are 20″ x 20″. Lexco Engineering & Mfg. Corp.

322. Orthopedic stockinette

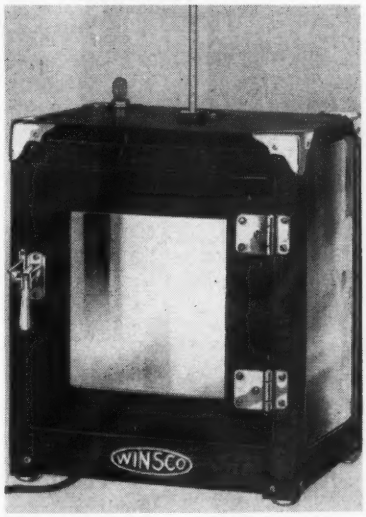
Orthopedic stockinette, available in tubular or bias cut. Can be used under plaster casts—is said to produce firmer, smoother cast. In single thickness it affords advantages of easier use, more elasticity, wider adaptability to hospital needs. Can be used for wrapping for fractures under plaster casts, as dressings for vein ligations, for pressure dressings, under adhesive tape for softness and added ease of removal. Adler Co.

324. Surgical buttons

Metal buttons which do not absorb drainage of wound. Clinical experience in many cases shows lower percentage of stitch infections, according to manufacturer. Easily applied with special compression forceps, and are removed with hemostat and scalpel. Graham-Field.



325. Bacteriological incubator



This incubator is designed for bacteria culture in laboratories. Unit is insulated with Fiberglas. It operates on small amount of energy — using single 25-watt heater bulb. Is equipped with ventilator and thermostatic heater control. Wabash Instruments & Specialties Co.

326. Skin freeze

New aerosol skin refrigerant. It is said to be noninflammable, nonexplosive, and of low toxicity. It is designed to obtain safe, quick, temporary anesthesia of skin by freezing. Contains dichlorotetrafluoroethane. Schuco Industries, Inc.

327. Irrigating apparatus

Irri-Mat, automatic irrigating apparatus, has been developed to provide method of irrigating indwelling gastrointestinal tubes at regular predetermined intervals. Can be used to moisten wet dressings at 10 or 20-minute intervals. Wabash Instruments & Specialties Co.

328. Magnetic stirrer

Explosion-proof air-driven magnetic stirrer. Developed to stir open or closed vessels in presence of explosive vapors or liquids. Labline, Inc.

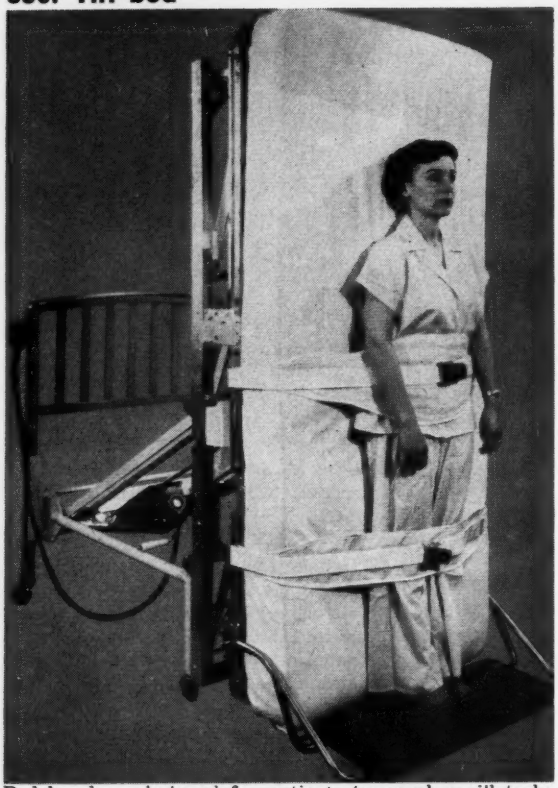
329. Lift trucks

Hydrolectric is a quiet operating tractor that can be used in hospitals to move trailers of food and train-loads of beds for the patients. Lift Trucks, Inc.

BUYER'S GUIDE

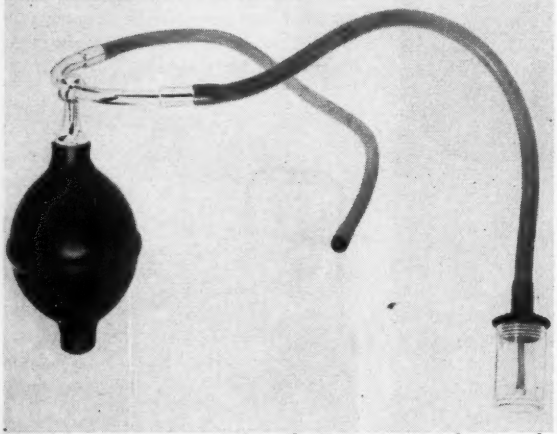
Continued

330. Tilt bed



Bed has been designed for patients too weak or ill to be transferred to tilt table for physical therapy. Provides all standard hospital bed positions and adjustments, plus added features of tilt table. Bed is adjustable from 10° Trendelenberg through full standing 90°. Franklin Hospital Equipment Co.

331. Laryngeal spray



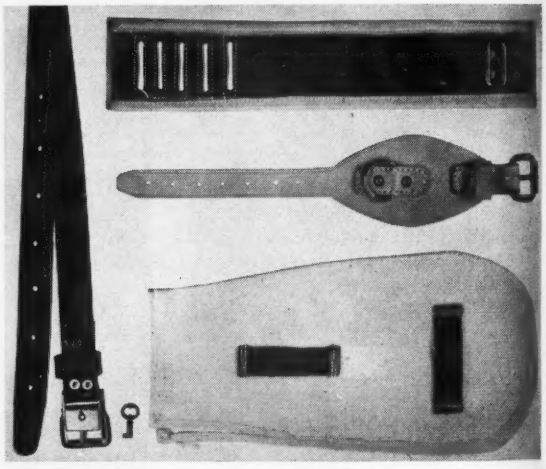
Plastic container mounted on flexible tube is below nozzle level to prevent siphoning. It is made of heavy-gauge rubber, and is antistatic. The Macintosh laryngeal spray is imported from England. Anesco.

332. Portable transcriber

Electronic transcriber has new three-dimensional sound system which emphasizes hard-to-hear sounds and softens harsh words so that recorded dictation becomes easier to hear. Has illuminated index panel that explains 15 minutes of recording at a glance. Thomas A. Edison, Inc.

333. Heavy-duty restraints

Restraints are fabricated for rugged service. Canvas mittens are flannel-lined, 7" x 14" over-all, with double-stitched web straps. Wrist and ankle bands have adjustable slots for quick closures. The bands resist irritation and provide firm restraint with as little discomfort as possible. Gockel Leather Co.



334. Clinical thermometer

Thermometer is special adaptation of liquid-actuated, clock-motor-driven portable recording thermometer. Sensing unit consists of scientifically designed stainless steel bulb of extreme sensitivity that can be inserted into rectum of patient without discomfort. Probe connected to recording thermometer by plastic-covered capillary tube. Weksler Thermometer Corp.

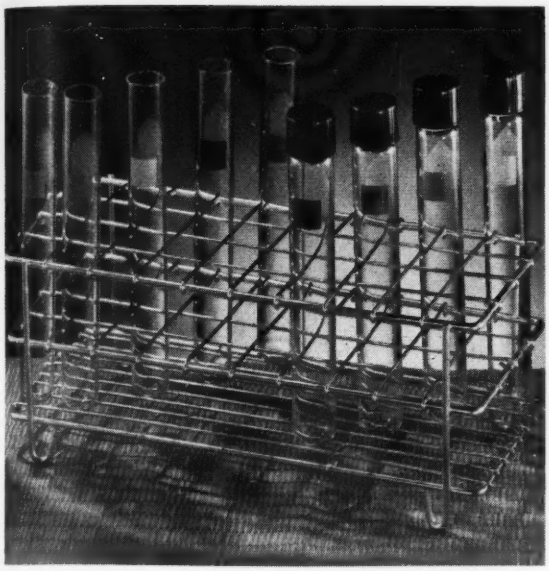
335. Ivy arm board

This board provides rigid support for patient's arm, and allows normal position in bed throughout therapy. The 9½" model is for intravenous administration at back of wrist or hand; the 14" one for use at elbow portal. Board is made of white opaque plastic. Harris Hospital Supply, Inc.

336. Electric steam generator

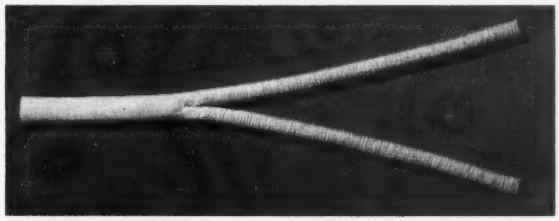
Generator produces steam instantaneously; may be used for autoclaves, sterilizers, stills, kettles, steamers, disinfecting apparatus, washers, or any apparatus requiring steam. Comes enclosed in stainless steel cabinet, ready for attachment to any apparatus. Hospital Supply Co. Inc.

337. Color-coded culture tubes



Color-coded culture tubes available with one-half inch squares of permanent color. Code colors: red, yellow, green, black, blue, white. Technician has seven tubes at his disposal — colors plus clear tube. Tubes available plain or with screw-capped top finish for plastic closures. Plain tubes are in three overflow capacities, 24, 28, and 55 mls. Screw-cap tubes have 20, 30, or 50 ml. capacities. Owens-Illinois.

339. Artificial aorta

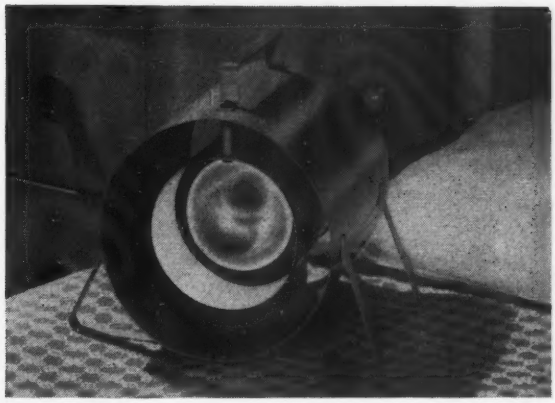


Artificial bifurcated aorta pictured at right is made of chemically treated braided nylon. Large part of tube is 5" long, limbs are each 9½" long. C. R. Bard, Inc.

340. Adjustable light

Lights adjust to any position and stay put at any angle. Metal shade remains cool and comfortable to the touch. Wall, floor, laboratory models available, also one model for attachment to hospital bed. Swivelier Company, Inc.

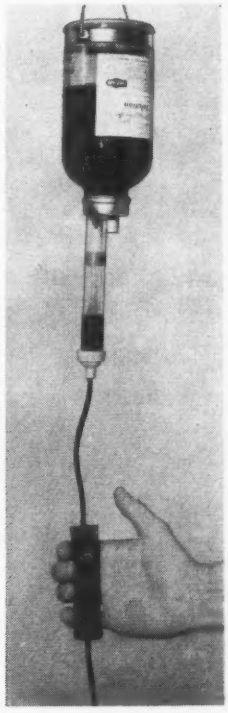
341. Radiant heat unit



"Heal-Lite" is designed for postoperative perineum heat treatments and for application wherever concentrated radiant heat is needed. Air space between aluminum shells prevents burn or electrical shock injury; foundation legs prevent upsetting. No sharp edges protrude to cause injury. Unit may be immersed in water for washing; may also be autoclaved. J & L Development Co.

342. New blood set

Set is for rapid blood administration under pressure. The "filter-then-pressure" system minimizes possible hazards from hemolysis because pressure cannot be applied to unfiltered blood. Pressure unit is separate from and below drip and filter chambers. Rapid filtration and effective removal of clots provided by large surface of filter filament. Rubber adapter cap eliminates air bubbles. Mead Johnson & Co.



344. Blood bottle

New "Sera-Vac" has sterile, vacuum pilot tube inside the blood bottle which cannot be mislabeled, interchanged, lost or broken. Clot retraction is improved because the internal pilot tube, warmed by blood around it, cools more slowly than tubes taped to bottle. Baxter Laboratories, Inc.

345. Knuckle bands

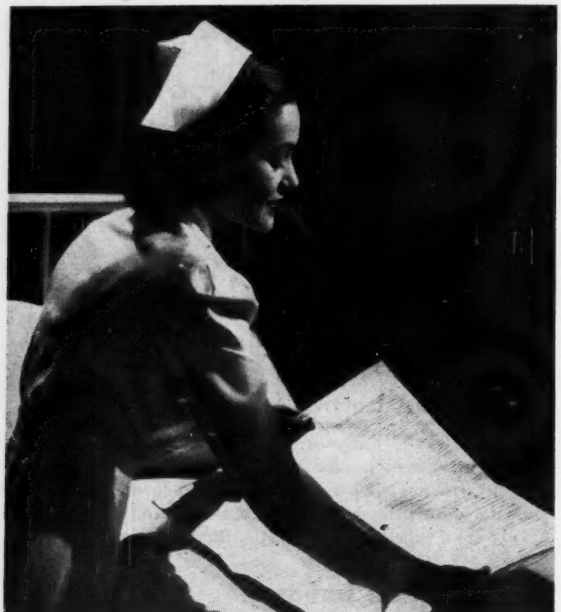
Knuckle bands for "hard-to-bandage" places are made of highly elastic material. Extremely tacky, yet permit free movement of injured parts. Flesh-colored bandages are individually wrapped and sterilized. Overall size: 1½" x 3". Medical Fabrics Co., Inc.

346. Urine sugar test

M-73
100 TESTS (APPROX.)
TES-TAPE
000 (Urine Sugar Test Tape, Lilly)
Directions: Remove approx. 1½ inches of 'Tes-Tape.' Dip in specimen; remove and wait one minute; then immediately compare darkest area with color chart below.
AX-28588-A ELI LILLY & CO., INDIANAPOLIS, U.S.A.
If tape breaks, cut here to open and rethread
APPROX.
0 + ++ +++ ++++
0% 1/10% 1/4% 1/2% 2% or more

"Tes-Tape" eliminates need for test tubes, heat, reagents, etc., in quantitative urine sugar determinations. Strip of tape moistened with specimen is compared with color chart on tape dispenser. Eli Lilly & Co.

347. Disposable bed pad



New giant-size underpad, 23" x 24", provides 30% more protection to bed and 30% greater absorptive capacity. Has a non-absorbent plastic coated backing paper, is faced with a non-woven fabric, and filled with multi-ply highly absorbent cellulose. Johnson & Johnson.

348. Stacking chair

Featuring simplicity of design, extra-durable construction, and an all-metal back, these chairs are easily stacked for multi-purpose rooms. Selected by Wisconsin for use in two new state hospitals. Royal Metal Mfg. Co.

349. Microscope illuminator

Designed to furnish a high intensity point source of illumination for microscopy, macrophotography, and microphotography, illuminator has a built-in transformer resulting in cool operation and long bulb life. Clay-Adams, Inc.

350. Portable resuscitator

This 30-lb. resuscitator is easily adjusted for infants as well as adults. Inhalation and exhalation pressures are controlled by dial. Rate of breathing can also be preset. Fyr-Fyter Co.

300. P
301. C
302. P
303. L
304. P
305. I
306. F
307. F
308. U
309. N
310. P
311. P
312. F
313. C
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316. S
317. H
318. P
319. S
320. H
321. L
322. C
324. S
325. B
326. S
327. I
328. M
329. L
330. T
331. L
332. P
333. H
334. C
335. I
336. E
337. C
339. A
340. A
341. R
342. B
344. B
345. K
346. U
347. D
348. S
349. M
350. P
351. F
352. C
353. L
354. B
355. P
356. A
357. D
358. P

NEW

370. I
371. P
372. S
373. F
374. F
375. P
376. R
377. F

BUYER'S GUIDE Information Service

300. Plastic filter chamber
301. Oxygen manifold control unit
302. Plastic coated cup
303. Location markers
304. Prone position pad
305. Inhaler tube
306. Felt tip pen
307. Floor finish
308. Under-the-bed drawer
309. Noiseless typewriter
310. Plastic strips
311. Portable anesthesia machine
312. Film hanger
313. Cold steam humidification
314. Water-conditioning agent
315. Blood-collection set
316. Surgical scissors
317. Heavy duty range
318. Patient lift
319. Sound projector
320. Hypoallergenic fruit juice
321. Linen truck
322. Orthopedic stockinette
324. Surgical buttons
325. Bacteriological incubator
326. Skin freeze
327. Irrigating apparatus
328. Magnetic stirrer
329. Lift truck
330. Tilt bed
331. Laryngeal spray
332. Portable transcriber
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357. Dictation planning
358. Plastic dinnerware

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380. Films dealing with health

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383. Harold Supply Corp.
384. Franklin C. Hollister Co.
385. Huntington Laboratories
386. Walter G. Legge Co.
387. Lehn & Fink Corp.
388. J. T. Posey Co.

CATALOGS

389. American Sterilizer Co.
390. Newman Brothers, Inc.
391. Sierra Engineering Co.

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393. Flex-Straw Co.
394. Lehn & Fink Corp.
395. Medical Case History Bureau

REPRINT

396. Birtcher Corp.

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30 West Washington Street

Chicago 2, Ill.

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300	309	318	328	337	348	357	377	386	395
301	310	319	329	339	349	358	378	387	396
302	311	320	330	340	350	370	379	388	
303	312	321	331	341	351	371	380	389	
304	313	322	332	342	352	372	381	390	
305	314	324	333	344	353	373	382	391	
306	315	325	334	345	354	374	383	392	
307	316	326	335	346	355	375	384	393	
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(Please Print)

Hospital .....

Address .....

City .....Zone .....State .....

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REPRINT

396. Birtcher Corp.

351. Face mask

ew line of anatomical face masks identified as "Trimar" yle. Masks have a more open nose section, less abrupt ntours in cheek and chin sections than the Cyprane sk. They have a wrap-around cushion instead of an erior one. Adult sizes are small, medium and large. ey will be furnished as standard on all Cyprane in-lers, and will be shipped as a replacement mask for e unit when specified. Ohio Chemical & Surgical Equip-nt Co.

352. Coil cotton

hite, non-absorbent, extra-strong long-fiber cotton. mes in coils; available in four weights. Uniform thick-ss makes it excellent for plugging culture tubes or any oratory operation which requires consistent amounts cotton. Comes packed six lbs. of any weight per carton. merican Hospital Supply Corp.

353. Ladder-truck

obile ladder-truck cuts cost of hospital overhead main-nance by reducing time usually required for washing, inting, and cleaning in high areas. "Safe-Lad" is easily led to the job, and a sturdy base tray provides ample rage space for tools and supplies. Automatically re-ctable swivel casters prevent horizontal movement, as nt end rests solidly on two rubber-tipped steel legs. light-weight metal platform with adjustable height ard rail may be bolted to the top step if desired. "Safe-d" Manufacturing Co.

354. Burn relief spray

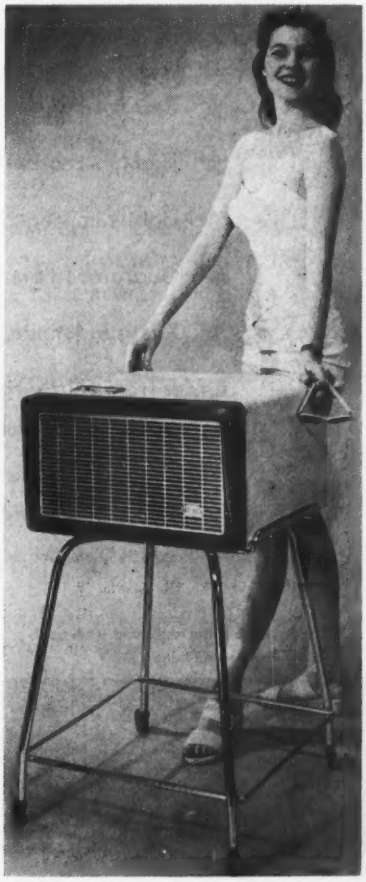
Push-button spray bomb treats burns and protects the skin with a cooling emollient film. Analgesic agents alleviate pain, and hexachlorophene precludes possible secondary infection. Invisible film deposited by the spray isolates the burn and keeps skin soft and moist, eliminating need for bandages or dressings. May also be used for minor skin irritations. General Scientific Equipment Co.

355. 'Battle Ribbon' plastic bandages

Designed with bright colors especially for children, Curad "Battle Ribbon" plastic bandages are now available in a new package of 100, for use by doctors and hospitals. Give vaccinations, cuts and scrapes a mark of distinction. Bauer & Black.

356. Air cleaner

Micronaire Mark II, electronic air cleaner, removes 99.2 percent of pollen, dust, smoke, other impurities from the air. Unit is compact and portable, and can be moved from room to room. Raytheon Mfg. Co.



FILMS AND NEW LITERATURE

370. Instrument disinfection

A disinfectant and antiseptic use chart put out by Lehn & Fink Professional Products Division on Amphyl. Stick figure drawings add appeal.

371. Patient care booklet

Booklet illustrates how hospitals can improve patient care and make maximum use of nursing time and skills. Included is summary of time and motion studies of nurse call systems made by surgeon generals' office of the army and the air force. Executone, Inc.

372. Surgeons' instruments catalog

Extensive illustrations of surgical instruments. Includes: ear and nasal instruments, instruments for neurosurgery, rib retractors, aorta clamps, and many more. Grieshaber Mfg. Co.

373. Freeze-drying equipment

Freeze-Drying Equipment for Laboratories includes descriptions of new freeze-drying units, vacuum gauges and pumps, bath coolers, and related laboratory small-scale production equipment. Arthur S. LaPine & Co.

374. Food service equipment

This 20-page catalog on food service equipment is the first in a series which will cover dietary and kitchen equipment. Includes complete specifications and dimensions for each type and style of truck. Jarvis & Jarvis.

375. Positions for nurses

Brochure put out by the National Institutes of Health tells of positions Clinical Center has to offer professional nurses. Clinical Center, National Institutes of Health.

376. Revised laboratory booklet

Catalog lists prices, specifications, and other information for four sizes of gas cylinders — B., D., M., and H. Specifications are included on: pressure regulator, metering regulator, single-stage pressure regulator. Also needle valves. Ohio Chemical & Surgical Equipment Co.

377. Furniture folder

Over 60 models of metal furniture are pictured in colorful six-page folder. Layout folder is included with scaled furniture as aid in preparing room groupings. The Howell Co.

378. Skin care brochure

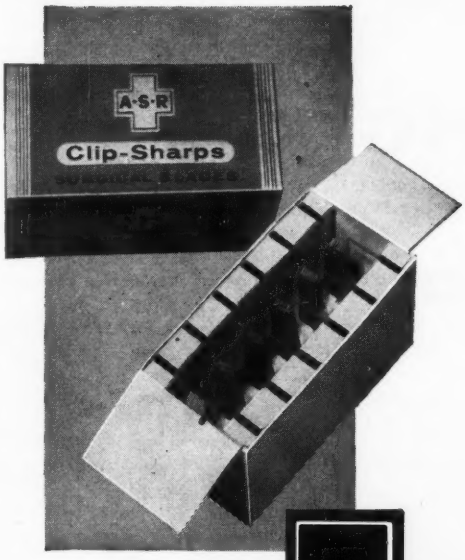
The Skin, an attractive pink and gray booklet, tells of routine procedures in caring for the skin, including skin conditioning. Also describes skin care for postoperative, geriatric, infant, and chronically ill patients. S. M. Edison Chemical Co.

379. Film listings

Brochure explains types of films available from the Center for Mass Communications of Columbia University. Includes series on the gastrointestinal tract and one on motor disorders in the nervous diseases.

380. Films dealing with health

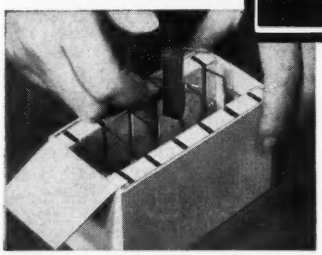
Motion pictures on laboratory techniques include subjects such as: "GSR Meets the Laboratory," "Infectious Hazards of Bacteriological Technics," and "Using Animals in the Laboratory." United World Films, Inc.



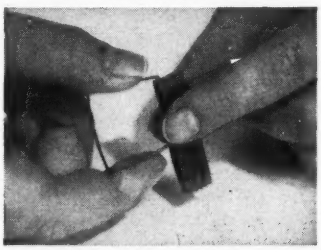
now! quick, easy blade sterilization with

A·S·R Clip-Sharps

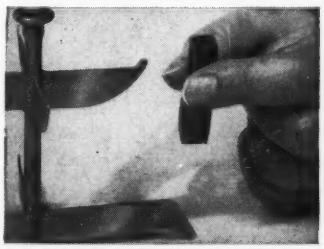
TRADE MARK



Remove cover – hold box in one hand. With other hand lift one wire holder (24 Blades) from box.



Grasp the wire clip between thumb and index finger and squeeze the wire. This releases the tension and enables the blades to be easily removed from the clip.



Holding the blades between thumb and index finger, simply slip them onto the rack. It's quick – and easy!

Clip-Sharps® are convenient wire clips containing 24 unwrapped A.S.R. Command Edge Surgical blades. There are six clips per box, protected by rust inhibiting paper.

Any sterilizing rack and any reliable, non-corrosive sterilizing agent may be used.

If you do not wish to sterilize the entire clip of 24 blades, remove only the required number from the clip and place them on the rack arm.

All A.S.R. Surgical Blades are Sharpometer tested. The A.S.R. Sharpometer, *only* device of its kind, measures the critical edge-fineness of every lot of A.S.R. Surgical Blades. These tests enable A.S.R. to guarantee . . . precise, uniform sharpness and dependability for every single blade!

NOW! For extra convenience, blades are alternated on clips.

Available through your Surgical Dealer.
Write for further information.

A·S·R **HOSPITAL DIVISION**
AMERICAN SAFETY RAZOR CORP.
380 MADISON AVENUE
NEW YORK 17, N. Y.

ARMSTRONG X-4

(Nursery Type)

Baby Incubator

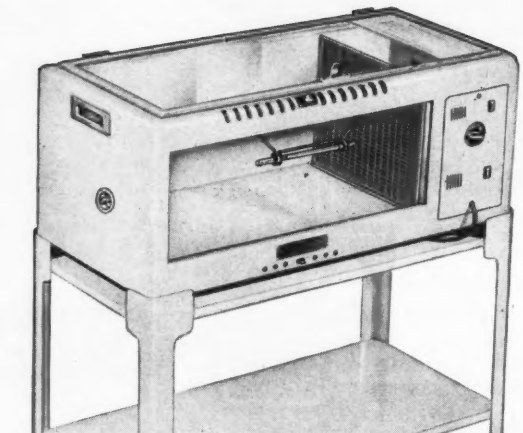
SAFE

RELIABLE

SIMPLE

LOW IN FIRST COST

LOW IN OPERATING COST



The Armstrong X-4 (Nursery type) is the original Armstrong baby incubator designed for safety, reliability, simplicity of operation, low initial cost and low operating cost. Experience-perfected and hospital-proven in the United States and 79 foreign countries. The X-4 was the first incubator ever to be tested and approved by Underwriters' Laboratories, Inc. and is still the low-cost Baby Incubator of choice for general nursery use.

Armstrong X-4 incubators may now be equipped with our 40% Oxygen Limiting Valve (which locks at either 40% or 100%) as accessory equipment at low cost. Use our *free telephone service*—phone us collect (reverse the charges) from anywhere in continental United States, Alaska or Hawaii when you are in a hurry or want rush service.

THE GORDON ARMSTRONG CO., Inc.

504 BULKLEY BLDG., CLEVELAND 15, OHIO, U. S. A.

Cleveland Telephone—CHerry 1-8345

OB DEPARTMENT

Hospital Holds Conference On Care of Newborn

• More than 140 doctors, nurses, and nursery personnel from seven states attended the recent two-day postgraduate conference on Hospital Care of the Newborn in Denver. The project was a joint venture of the Mid-West Hospital Association and the University of Colorado School of Medicine. Classes were held at General Rose Memorial Hospital.

According to Hubert Hughes, president of the Mid-West Hospital Association and administrator of General Rose, the success of the program points out the type of thing that a regional hospital conference can do.

One of the guest speakers, Robert H. Lowe, M.D., superintendent, Indianapolis General Hospital, created quite a controversy by advocating the use of the autoclave in the clean section central supply room for the preparation of formulas.

Dr. Lowe

Dr. Lowe contends that special formula preparation rooms are unnecessary when the central supply room is open 24 hours a day. Central supply personnel, he says, could be trained to prepare formulas in the slack hours at night, since they are already trained in the use of the autoclave. The best method of preparing formulas, in Dr. Lowe's opinion, is to boil the milk at 230° for 10 minutes. He said that the usual method of 250° for five minutes caramelizes the formula.

Following are abstracts of some of the papers presented at the conference.

Study of Perinatal Mortality Belongs in Individual Hospital

Social and Economic Factors
Affect Rate of Prematurity

Perinatal mortality studies are projects for individual hospitals—not state or local health departments. Sometimes when a hospital begins a study of mortality, this in itself brings good results.

In a study of 1,043 perinatal deaths at Johns Hopkins from 1937 to 1949, 54 percent were found to be fetal or premature deaths. In a study of the causes of premature birth, maternal disease accounted for 24 percent; congenital abnormalities, 1.6 percent, and multiple pregnancies, 11.9 percent. In 60 percent, the cause was unknown. We must have further studies on the causes of premature birth.

Our study showed that this is also a social and economic problem. Deaths of infants weighing from 1,000 to 2,500 grams occurred in five percent of the private patients, 7.6 percent in the white ward, and 13.4 percent in the Negro ward.

We have also noted that the bulk of premature births are from complicated pregnancies. Thus, if there are not enough facilities, the baby who comes from a complicated pregnancy gets priority.

In a study of methods of resuscitation, babies weighing less than 2,000 grams, from the ward services, were placed in the Bloxsom air lock machine or an Isolette, on an alternate basis. No statistically significant difference was shown by the use of the air lock.—**Harry H. Gordon, M.D.,** Chief of Pediatrics, Sinai Hospital of Baltimore, and Associate Professor of Pediatrics, Johns Hopkins University School of Medicine.

Panel on Premature Infant Care

Panel members: Harry H. Gordon, M.D.; Esther W. Ott, R.N., Obstetrics Supervisor and Instructor, Newborn and Premature Infant Nursing, University of Colorado School of Nursing, Denver; Lula O. Lubchenco, M.D., Assistant Professor, Department of Pediatrics, University of Colorado School of Medicine, Denver.

Q. What are the indications for gavage feeding?

MISS OTT: If the nurse finds that the baby is listless, she should contact the doctor about the advisability of gavage feeding. It should be discontinued on the doctor's orders only.

(Continued on next page)

Above: Waiting for the first session to begin are Harriet Tresemer, R.N., premature nursery, St. John's Hospital, Tulsa, Okla., and Sister Mary Irma, obstetrics supervisor, St. Francis Hospital, Wichita, Kan.

Above: Group discussion on problems of small hospitals interested Lydia Ballin, R.N. (l.), obstetrical supervisor, Logan County Hospital, Sterling, Colo., shown conferring after the meeting with Betty L. Highly, R.N., instructor, obstetrical nursing, University of Colorado School of Nursing, Denver.

Above: Two of the many persons who planned the successful program, John A. Lichty, M.D. (l.), associate professor, department of pediatrics, University of Colorado School of Medicine, and Hubert Hughes, administrator, General Rose Memorial Hospital.

Above: Three panel members continue their discussion after the program has officially ended. (L. to r.): Harry H. Gordon, M.D., Baltimore; Lula O. Lubchenco, M.D., assistant professor, department of pediatrics, University of Colorado School of Medicine, and Shirley C. Booth, R.N., Denver.

Above: Three guest speakers (l. to r.): Harry H. Gordon, M.D. Paul D. Bruns, M.D., associate professor, department of obstetrics and gynecology, and Robert L. Stubblefield, M.D., associate professor, department of psychiatry, both from the University of Colorado School of Medicine, Denver.

OB Continued

DR. LUBCHENCO: If the baby is unable to suck, gavage feeding is indicated.

DR. GORDON: Gavage feeding is advised for any baby who cannot suck or swallow or becomes exhausted quickly from sucking. The indwelling catheter is a great help because not all nurses are acquainted with this method and know how to insert the tube. There are some disadvantages. We wonder if the catheter does not obstruct the airways some, and there is the danger that the baby can regurgitate around the tube.

Q. How often should the catheter be changed?

MISS OTT: At least once a week. We never leave the catheter in longer than five to seven days.

Q. What can we do to prevent hyaline membrane disease?

DR. GORDON: We are often too afraid to move the babies to the x-ray department or to have anyone come in. Thus we are denying them the best diagnostic care. Also, we should constantly check the oxygen concentration. You usually can get a good idea of the baby's condition after it has been in a 40 percent concentration for 12 hours.

Q. What about the proper method of withdrawal of oxygen?

DR. GORDON: The method of withdrawal depends on how long the baby has been in oxygen.

DR. LUBCHENCO: We do not like to withdraw the baby abruptly. But it can be done in hours instead of days.

Q. Should gowns and masks be worn in the nursery?

DR. LUBCHENCO: A nurse wearing a mask all through an eight-hour shift can be very dangerous. This does not hold true for doctors.

MISS OTT: We do not use masks at General Rose Hospital. Nurses caring for prematures wear hairnets and scrub gowns.

DR. GORDON: We feel that the best method of protecting against disease is to keep an eye on the contagious diseases in the city and to limit visitors.

Q. Do you advise routine throat cultures on nursery personnel?

DR. LUBCHENCO: We have tried it, but it has proved unsatisfactory. It is best if the nurses decide for themselves if they are sick.

Panel on Special Problems of Small Hospitals

Panel Members: Robert H. Lowe, M.D., Superintendent, Indianapolis General Hospital; John A. Lichty, M.D., Associate Professor, Department of Pediatrics, University of Colorado School of Medicine, Denver; Betty L. Highly, R.N., Instructor, Obstetrical Nursing, University of Colorado School of Nursing, Denver.

Q. What can we do about the practice of bringing patients from overcrowded floors to the obstetrical floor? This happens in small hospitals quite often and the doctors aren't always too careful about the type of cases they bring in.

Right: Leaving the meeting at General Rose (l. to r.): Helen Ash, R.N., nursery supervisor, Utah Valley Latter Day Saints Hospital, Provo; Florence Canty, nursery employee, Community Hospital, Alamosa, Colo.

DR. LOWE: Get accordion-type partitions to create separate units. Ask your administrator to devise some method to divide the obstetrical floor.

DR. LICHTY: We might give some consideration to mixing clean surgical cases and obstetrical cases.

Q. What about Dr. Lowe's proposal for making formula in the autoclave in the central supply room?

DR. LICHTY: This practice would be especially valuable in the small hospital.

DR. LOWE: The plan has been approved by Hill-Burton. The boiling method is not too reliable so it is much better to use the autoclave.

Q. Is it necessary to autoclave linens for use in the newborn nursery?

DR. LICHTY: It is necessary for use in the premature nursery, but not in the full-term nursery.

Q. Our hospital is located in a small town in a farming area. People come into town on business and stop in at the hospital with no concern for visiting hours. It now has become a social custom. How can we get these people to observe visiting hours?

DR. LICHTY: You must educate visitors just as you educate your staff. Visitors must realize that their unscheduled visits disrupt the nurses and patients and increase the danger of infection. One nurse I know started a little newspaper for patients and visitors to make them aware of the consequences of not observing visiting hours.

MISS HIGHLY: Prospective mothers should be told about visiting privileges during the prenatal period. Mothers sometimes appreciate the limitation of visiting hours and will pass the word along to their families.

Nurses Invited Regularly On Attending Rounds

Weekly Morbidity Conferences
Aid in Staff Education

In setting up our teaching program at Sinai Hospital we wanted to avoid the repetition of mistakes and a self-righteous attitude. We have set up a program of attending rounds for nurses and doctors, and private patients are used as well as ward patients. Nurses are invited to go on the attending rounds three times a week, and this custom gives us a major teaching opportunity. The rounds have resulted in better cooperation between the obstetricians and pediatricians and the pediatricians and general practitioners.

We have a neonatal mortality conference once a month and a weekly pediatric-obstetric morbidity conference. For one-half hour each week, the obstetricians, pediatricians, nurses, and social workers get together to discuss patients who have not done well. For instance, we may discuss a baby who has developed an intestinal obstruction, and everyone present at the conference learns when a bowel should start functioning in the newborn.

All patients are available for teaching purposes. We are not trying to destroy the doctor-patient relationship, but rather to establish a system for communication and education within a community hospital—**Harry H. Gordon, M.D.**, Chief of Pediatrics, Sinai Hospital of Baltimore.

Left: Two of the conference faculty members (l. to r.): Robert L. Denholm, director of hospitals, Colorado General Hospital, Denver, and James C. Schafer, assistant director, Colorado Hospital Service, Denver.

Obstetrician's Main Responsibilities: Maternal Disease, Complications

Complications Most Often Occur
In Youngest and Oldest Mothers

The obstetrician's responsibilities fall into two major categories: maternal diseases, such as heart disease, diabetes, anemia, and essential hypertension, all of which must be treated early in pregnancy; and obstetric complications, such as toxemia, placenta previa, placenta abruptio, and the early diagnosis of twins.

Toxemia occurs most often in the very young primipara or in the woman in the twilight of her reproductive career. It is due to the imbalance of sodium and water, but we do not understand too much about it.

In the case of threatened placenta previa or abruptio, we hospitalize the patient immediately and try to keep the baby in utero as long as possible.

The obstetrician's interest lies in two fields: why babies die in utero and why they are born prematurely. Intrauterine physiology studies show that in the women who deliver prematurely there has been uterine activity above normal long before birth and that there has been a low excretion of hormones. Usually as pregnancy progresses, the estrogen production goes up. Those who delivered prematurely showed less production of estrogens.—**Paul D. Bruns, M.D.**, Associate Professor, Department of Obstetrics and Gynecology, University of Colorado School of Medicine, Denver.

'Above: Speakers at the postgraduate conference on hospital care of the newborn were: (l. to r.): Hubert Hughes, administrator, General Rose Memorial Hospital, and president, Mid-West Hospital Association; Harry H. Gordon, M.D., chief of pediatrics, Sinai Hospital of Baltimore; Shirley C. Booth, R.N., associate director, nursing service, University of Colorado School of Nursing, and James C. Schafer, assistant director, Colorado Hospital Service, Denver.

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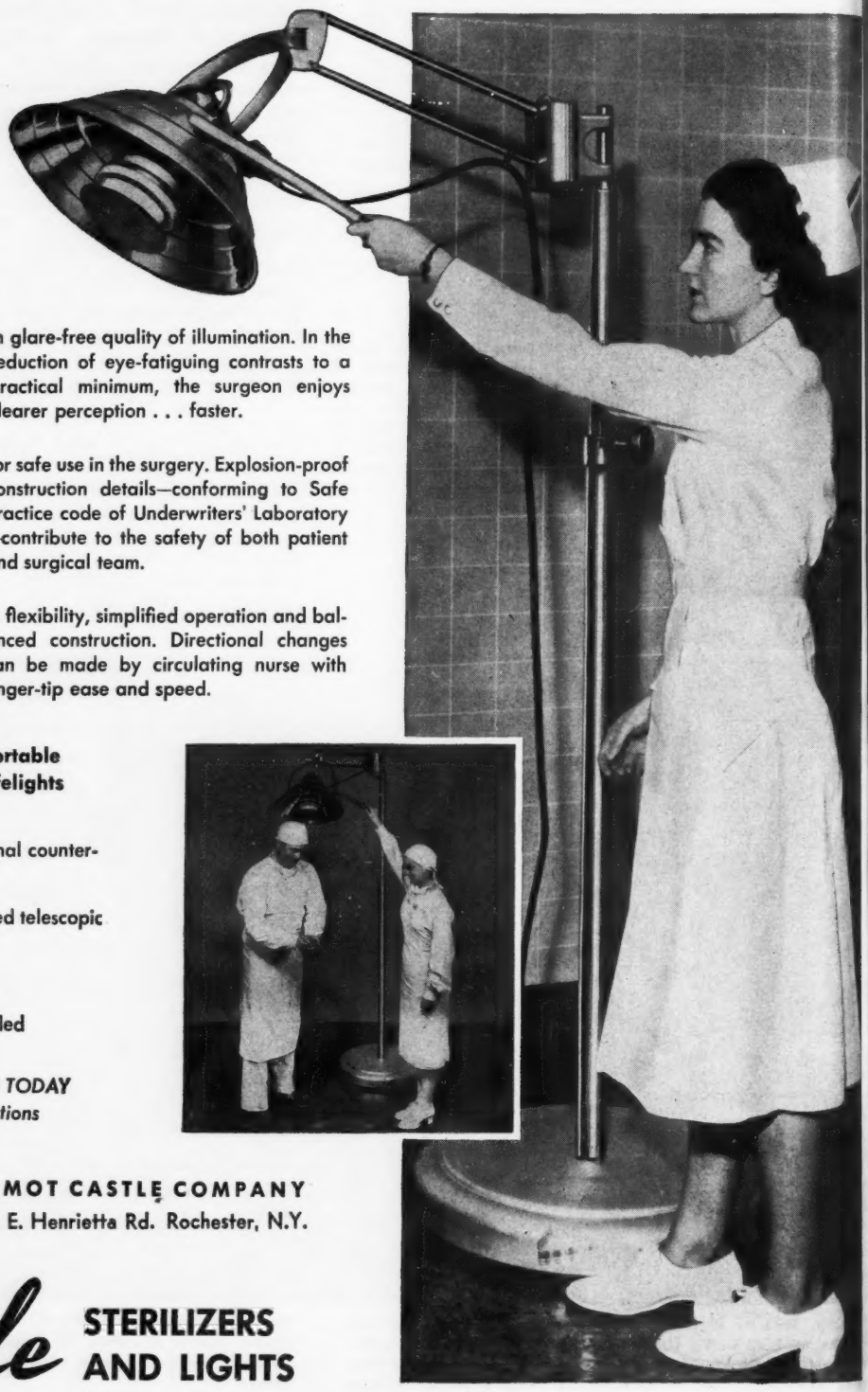

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1. Cross, Frederick S., M.D.: Clinical Medicine, 1121-1125, November, 1955.
2. Hosler, Robert M., M.D., Cleveland, Ohio: A Manual on Cardiac Resuscitation, Charles C. Thomas—publisher, 1954.

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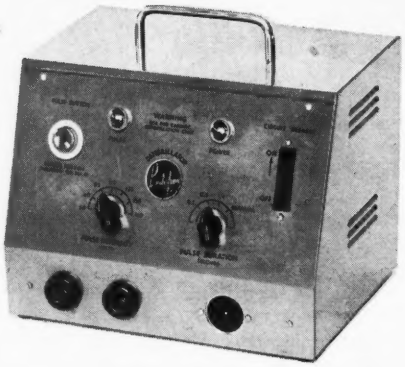

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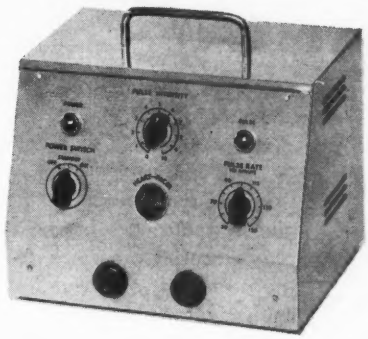

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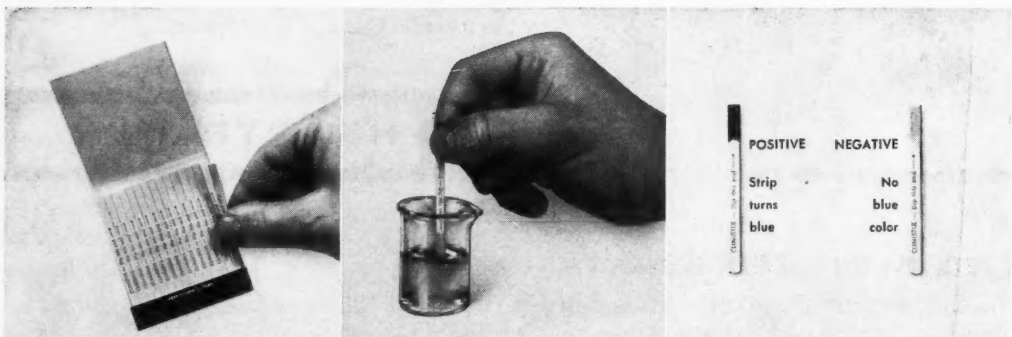

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Preparing the Child For the Hospital Stay

Pediatrics

By Henry H. Fineberg, M.D.

To prepare the child for hospitalization, it is necessary to know as much about him as we can learn. We must know the personality and adjustment of the pre-illness child. We should know what his developmental experience has been and his responses to the various tasks presented from both his internal and external environment. Only with this knowledge can we understand the effect of illness and threatened hospitalization upon our patient.

We must know whether the child was disturbed and neurotically symptomatic before the illness, so that we may determine whether his present emotional responses were precipitated by this illness, the anticipation of separation, and the fears related to hospitalization.

It would be important also to know what this child's previous illness experience was. Were there events that were frightening and painful about which he needs reassurance at this time? All this information would help us to determine the procedure to be followed in preparation.

Obviously, we cannot set up a stereotype to be applied to all children, since the needs will vary tremendously. However, the information obtained through careful history and study of the pre-illness child will make possible some prediction of his reactions and will certainly give direction to the help offered.

APPROACH TO INSECURE CHILD

The child who is insecure in his family relationships --that is, one raised in a home which he felt was not adequately protective or that did not provide enough consistent controls to put him at his ease—will require more work in the preparation for hospitalization and perhaps a little different approach than the more secure individual.

This is no time for us to attempt to solve the old problems of insecurity in our little patient's life. We are more inclined at this point to operate along more expedient lines in order to carry the disturbed child over the crisis, and so we should permit him and his parents more mutual contact in the hospital than the child who doesn't feel the need for his parents in quite the same way and who has learned to trust his physician and friendly adults more easily.

Having a family physician who is familiar and with whom the child has experienced the necessary medical care in growing up make the preparation problem far easier and no doubt give us a much more cooperative child who would respond to care with better results.

Dr. Fineberg is director, Child Guidance Clinic, Children's Memorial Hospital, Chicago. This paper was part of a symposium on "The Hospitalized Child," given at the Tri-State Assembly, Chicago, April 30-May 3, 1956. Another paper from this session will appear in this department in the October issue.

In general, the efforts of preparation should be directed toward understanding the hospital routines and enabling the patient to anticipate situations he will encounter. This preparation should cover only the experiences in the immediate future, so that he is carried along step by step by the hospital staff and parents in a forthright and reassuring manner. He should not be overwhelmed with too much information.

He should know his doctor and should feel free to ask what he wishes to know. In this regard I would advise that the physician give a reasonable explanation of the disease and procedures to the parents early and carefully, so that they are able to reassure the child with confidence.

The child should know his nurse or nurses. One nurse should introduce the next, or perhaps the doctor can do this so that there will be continuity in the relationship. The nurse should carefully explain what she will do for him and what he may ask of her. It is important that parents explain that they will be available at all times within regulations set by the hospital, so that the child may know what to expect in this area. Very simply and encouragingly the parents or doctor should explain why he is in the hospital and, if necessary, permit him to express his fears so that they may be clarified. Children may have gross misconceptions about the nature of the illness and the hospital procedure, which may have derived from misconceptions and attitudes of parents.

The physician should explain carefully to the anxious parent the problem and the procedures, giving him a reasonable opportunity to air his anxieties and to ask questions. A simple fact told by an unnecessarily frightened parent will produce a frightened child with a distorted conception of ordinary material.

REACTIONS TO NEW SITUATION

In regard to the adjustment of the child to the hospital, we are again concerned with his pre-illness personality. We can expect that he will react for the most part as he has always reacted to various situations, with the added changes superimposed by the new situation and new anxieties.

The child with any of the many problems which make limitation and interpersonal activity difficult will be a much greater problem than the child who is (so-called) well adjusted to normal limitations and interpersonal activity which he may have encountered before his illness.

Perhaps I should briefly explain this last statement.

(Continued on next page)

Children who are raised to understand and abide by reasonable rules of living have learned to respond not only to external controls, but have incorporated to some degree—depending on age and training—internal controls which help them when the authority figure is not present.

However, the child who lives in a very inconsistent environment in which reasonable rules are not adhered to and he cannot predict the attitudes and wishes of parental figures, cannot learn what he is expected to and therefore cannot internalize adequate controls. With such children the interpersonal interaction is inconsistent and turbulent and, in the hands of a hospital staff not prepared for the emotional problems presented, it goes from bad to worse.

CONSTRICTIONS ENCOUNTERED

For all children the hospital situation represents a constricting if not immobilizing experience. Normally our patient has been accustomed to more or less free expression of aggression in words and actions. In the hospital he is brought up abruptly, first, of course by the limitation of his illness and the pain, then the fear of a new situation and what will happen to him—the cage-like bed, the limitation of authoritative figures around the hospital.

The little baby or the severe dermatological problem may even be tied down.

Then there are the "ever-present hospital rules." As a result the "pre-illness well-adjusted child" will demonstrate evidences of disturbance either in the direction of difficult-to-manage behavior, or withdrawal and regression. In addition, some of our hospital practices place the child in considerable conflict, especially in relation to the very hard-to-come-by socialization and training. This is accomplished by the marked lack of stimulation and tacit permission to regress, most remarkably demonstrated by the child whose toilet training breaks down and who begins to soil and wet again.

OFFER INCREASED CARE

It is my recommendation that considerable effort be directed towards stimulating all children hospitalized for more than several days by means of supervised group activities and considerable individual care above and beyond the good custodial care offered in all hospitals. I think that such procedure would enhance recovery and reduce the number of hospital days required, not to speak of maintaining the gains achieved by the growing child in normal development instead of permitting regression which we see all too often. I am fully aware of the tremendous shortage of skilled hospital personnel for increased care of children. However, specialists from other fields can be drawn upon—such as group social workers, occupational therapists, etc.

For the disturbed child, child guidance consultation should be available.

Technic of Giving Anesthesia Less Important Than Side Factors

Pre-Surgical Preventive Measures Needed Against Infection and Dehydration

As long as pediatric anesthesia is given well, the exact technic is not as important in the long run as the various side elements to be watched before surgery.

Routines do not apply in giving medication. Weight, physical condition, and age determine the amount of medication.

Children are prone to upper respiratory infections and should be watched carefully during their hospital stay. We advise hanging a sign on the crib warning adults to handle the child as little as possible, especially when he is being taken to several different departments.

The fluid intake is another important element before and during surgery. Infants lose fluid just during the time required for admitting procedures. They may go for hours with no fluid intake because of the lack of time or attention. We try to give fluids, sugar water, or fruit juice until about four hours before surgery. Children, then, must be worked into the surgery schedule at the proper time.

During surgery it is easy to give too much fluid. No more fluid is put in the flask than the child can assimilate at once in case there is an accident with the apparatus. About 10 cc. per pound is the limit.

Except for using hypothermia in cardiac surgery, we try to keep the children as normal as possible—especially their temperatures.

During the induction of anesthesia we use the smallest equipment available and try to get masks to fit the face.

In draining the gastrointestinal system, the size of the endotracheal tube is important. The tubing that will fit the external nares will usually fit the larynx. We keep one size larger and one size smaller on hand, in case the first is not right. The length of the tubing is important because it must be kept from entering the bronchi. One to 2 cm. is usually all right for a small baby.—**John P. Garvin, M.D.,** Chief of Anesthesia, Children's Hospital, Assistant Professor of Anesthesia, Ohio State University, Columbus. *(Abstract of a paper presented at the annual meeting of Ohio State Association of Nurse Anesthetists, April 11, Columbus.)*

New Drug Said to Aid Appetite, Improve Children's Behavior

Good results with a new drug in the treatment of children with loss of appetite, failure to gain weight, and mild symptoms of behavior problems are reported by Louis S. Goldstein, M.D., director of pediatrics, Yonkers (N.Y.) Professional Hospital.

The drug* combines vitamins B_1 and B_{12} with small doses of reserpine. Dr. Goldstein, writing in the *International Record of Medicine* 169:6 (June, 1956), describes results following its use in 56 infants and young children.

A child's failure to gain weight, according to Dr. Goldstein, usually is the direct result of simple loss of appetite, which may be attributed to failure to develop satisfactory eating habits.

Moreover, he said, many such children show ample evidence of irritability, hyperexcitability, and allied minor disturbances, are difficult to bring to the table at mealtimes, fidget and "pick at their food," and are impatient to leave the table before finishing their meal.

Fify-five of the 56 children treated with the drug showed a marked increase in appetite within one month after treatment was started. Dosage used was one tablet three times daily.

Irritability and hyperexcitability were reduced, and there was improvement in school work and in general behavior. The children were less stubborn and more congenial with family and friends, fatigue was eliminated, and speech habits were improved. A marked improvement in sleeping patterns also was noted.

There appeared to be no risk of toxic reaction, even after prolonged daily dosage.

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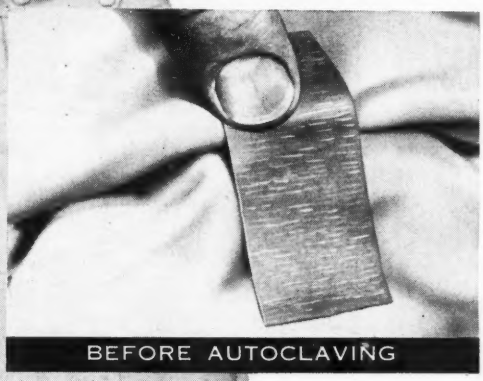

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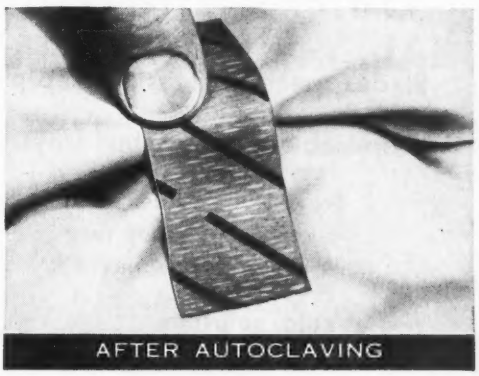

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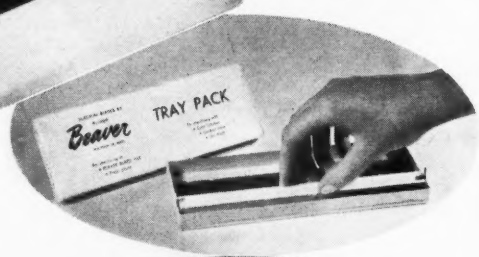

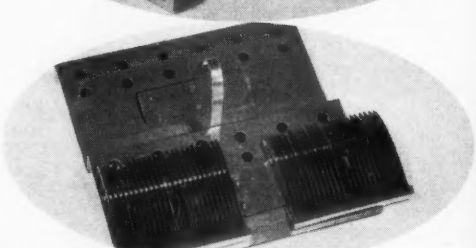

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PERSONALLY SPEAKING

(Continued from page 60)

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Francesco Mogavero, M.D.—chief surgeon, Misericordia Hospital, Philadelphia, Pa., died July 22.

William Neill Jr., M.D.—formerly on the staff, Howard A. Kelly Hospital, and partner, Kelly Clinic, Baltimore, Md., died June 24.

J. H. Nies—65, assistant controller, College of Medical Evangelists Hospital and Sanitarium, Loma Linda, Calif., died July 19.

Guy Payne, M.D.—78, former superintendent and medical director, Essex County Hospital, Cedar Grove, N. J., died July 2.

Karl Singer, M.D.—director, department of hematologic research, Michael Reese Hospital, Chicago, Ill., died July 12.

Sister Mary Anna—senior Sister and a founder, St. Joseph's Hospital, Boonville, Mo., died June 23.

William T. Smith, D.D.—executive director, Methodist Hospital, Peoria, Ill., died July 31.

Elwyn E. Terrill, M.D.—55, on the staffs, California and Georgia Street Receiving Hospitals, Los Angeles, Calif., died July 30.

Emanuel Waldinger, M.D. — 57, former medical director, Saybrook (Conn.) Rehabilitation Center, died June 30.

Daniel W. Zahn, M.D.—45, medical director, Firland Sanatorium, Seattle, Wash., died May 6. He was nationally known for his research in tuberculosis.

VA Appointments

Ivan F. Bennett, M.D.—has been appointed chief of psychiatric research, psychiatry and neurology service of VA central office, Washington, D.C. He was formerly at the VA Hospital, Coatesville, Pa.

John D. Bosler—has been appointed manager, VA Hospital, Syracuse, N.Y., succeeding **George O. Pratt, M.D.**, who resigned. He was formerly assistant manager, VA Hospital, Albany, N.Y.

Benjamin A. Cockrell, M.D. — manager, VA Hospital No. 88, Memphis, Tenn., has resigned.

Jackson H. Friedlander, M.D.—has been appointed manager, VA Hospital, Big Springs, Tex., succeeding **Ira G. Sims**, who has been transferred to the VA center, Whipple, Ariz. He was formerly chief, residency and internship program, VA central office, Washington, D.C.

(Continued on page 88)

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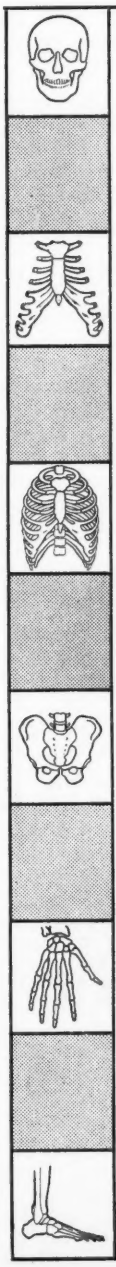

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This book may be described as an anatomic introduction to the *Standard Nomenclature of Diseases and Operations* or as an anatomy correlated with the *Standard Nomenclature.* Anatomic terms, as they occur in the text, are given their proper topographic code numbers, and anatomic parts sketched in the illustrations are likewise marked with their code numbers. A study of this *Anatomy* will thus at the same time convey an understanding of the *Standard Nomenclature.*

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PERSONALLY SPEAKING

(Continued from page 87)

Richard L. Jenkins, M.D.—has been appointed director, VA psychiatric evaluation project, headquarters in VA Mt. Alto Hospital, Washington, D.C. He was formerly chief of psychiatric research, psychiatry and neurology service of VA central office, Washington, D.C.

George M. Leiby, M.D.—has been appointed manager, VA Research Hospital, Chicago, Ill., succeeding **Michael L. Matte, M.D.**, reassigned to VA Hospital, Los Angeles. He was formerly director of professional services, VA Hospital, New York City.

Arnold E. Mouish — has been named special assistant to manager, VA Hospital, Northport, Long Island, N.Y. He was formerly personnel officer, VA Hospital, Louisville, Ky.

Joseph H. Van Schoick—has been appointed chief of corrective therapy, Washington, D.C., succeeding **John E. Davis, M.D.**, who retired. He was formerly special assistant to VA director of physical medicine and rehabilitation, Washington, D.C.

Marjorie P. Wilson, M.D.—has been appointed chief, residency and internship program, VA central office, Washington, D.C. She succeeds **Jackson H. Friedlander, M.D.**, appointed manager, VA Hospital, Big Springs, Tex.

PERSONALS

Stephen G. Gessner, Jr.—has been named business manager, Hospital of St. Raphael, New Haven, Conn.

Margaret Giffin — has been appointed director, Department of Hospital Nursing, National League for Nursing. She succeeds **Marian Alford,** who will become executive secretary, California State Nurses' Association.

Dorothy Gilman—has been appointed assistant administrator, Medical-Dental and Cobb Hospitals, Seattle, Wash. She was formerly assistant administrator, Doctors Hospital, Seattle, Wash.

Betty E. Guda — has been appointed executive housekeeper, Southern Baptist Hospital, New Orleans, La. She was formerly executive housekeeper, Ohio State TB Hospital, University Medical Center, Columbus, O.

Thomas A. Harrington—has been named assistant administrator, Pittsfield (Mass.) General Hospital.

Frank Harris—has been appointed superintendent, Louise G. Wallace Memorial Hospital, Lebanon, Mo., succeeding **Miss Nellie Mumford, R.N.**, who resigned.

Jane Hartman — has been appointed Food Service Specialist, Connecticut Hospital Association's Project Dietary Committee. She has been Food Service Director since 1950.

Jerome L. Heard, M.D.—has been appointed assistant pathologist and associate medical director of the blood bank, Southern Baptist Hospital, New Orleans, La. Formerly he was a pathology resident at the hospital.

John C. Hess—has been appointed administrator, Midland (Tex.) Memorial Hospital. He was formerly administrator, King's Daughters' Hospital, Staunton, Va.

Mrs. J. D. Hossler—has been appointed administrator, Woodland Hospital, Moberly, Mo. She was formerly office manager and assistant administrator, Eldora (Ia.) Memorial Hospital.

MISS PHOEBE

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Everest & Jennings chairs *are* lightweight—
yet no wheel chair on the market
is stronger or has better balance.
E & J's longer life and maintenance-free
operation will make your cost-accountant
sit up and take notice.
In the long run, E & J's cost less.

Specify **EVEREST & JENNINGS** chairs
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EVEREST & JENNINGS, INC., 1803 PONTIUS AVE., LOS ANGELES 25, CALIF.

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STERILE PACK SURGICAL GUT

Keeps broken glass out of the O.R.!

Improves patient care!

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Sterile Surgical Gut, USP
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D&G Atraumatic® needle sutures in the new Surgilar sterile pack

Improved patient care with New

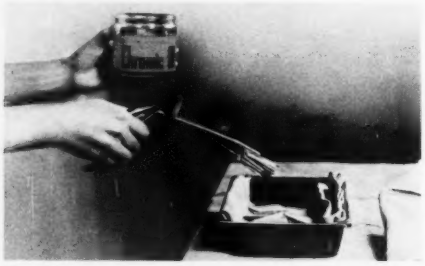
D & G SURGILAR*

Sterile pack surgical gut

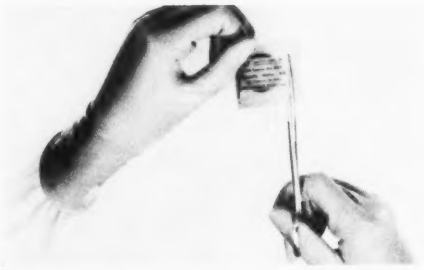
- Eliminates hazards of broken glass
- Delivers stronger, more flexible gut
- Greater protection for needle points
- Frees more nurse-power for surgeons

ATRAUMATIC® needle sutures now available in SURGILAR sterile pack

See how easy Surgilar is to use!

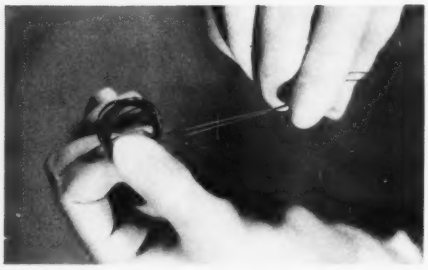


1. Improves patient care! Surgilar eliminates the dangers of broken glass in the operative field. Circulating nurse can remove 1 to 8 envelopes of standard length or ATRAUMATIC needle sutures at a time with one quick motion.



2. More nurse-power for surgeons! Suture nurse saves 33⅓% handling time—just one snip of the scissors opens the new D & G SURGILAR envelope. And with fresh, sharp ATRAUMATIC needles there's no need to thread, sterilize or sharpen. Nurses are freed for other important duties.

3. No more shattered tubes! Suture nurse quickly removes sterile, ready-to-use standard length or ATRAUMATIC needle suture, individually wrapped in easy-to-read label. Nurses report fewer worries about cut gloves, damaged linens and accidental tube breakage.



4. SURGILAR delivers more flexible gut! Suture nurse quickly straightens loose coil of superior gut. Surgeons report D & G SURGILAR delivers a stronger, more flexible strand of gut, free from kinks and weak spots often caused by tight reel-winding. Costs no more than tubes.

Ask your D & G representative for more information or write Director of Professional Relations.

D&G hospital-tested packaging makes the difference

*Trademark PRINTED IN U.S.A.

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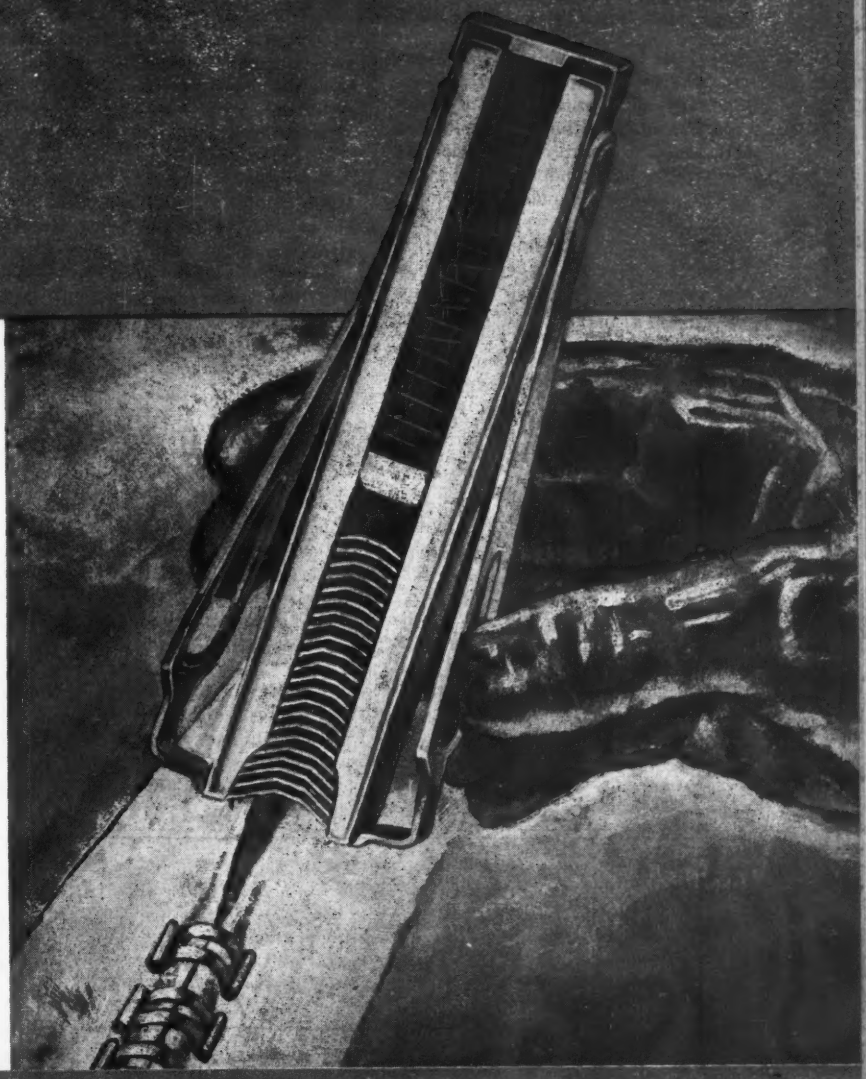
A DIVISION OF AMERICAN CYANAMID COMPANY
DANBURY CONNECTICUT

AUTOCLIP APPLIER

for placement of wound clips... AUTOMATICALLY



Pat. Apps. for

AUTOCLIPS® have all the advantages of fast, easy wound-clip skin closure: rapid healing; better cosmetic result; minimum of tissue trauma; easy, painless clip removal. The Autoclip Applier is lightweight, convenient, simple and fast!

AUTOCLIP APPLIER.....$23.50 REMOVER.....$6.00

AUTOCLIPS.....$2.40 per 100; $22.00 per 1000

Order from your dealer. He also stocks: **Intramedic Polyethylene Tubing · CRI Germicide · Castor Tube · Medichromes · Franklin Bilirubin Test**

Clay-Adams NEW YORK 10

INTRO

Ciba Pharmaceutical Presents Endocrine Society Award

Alfred M. Bongiovanni, M.D., associate professor of pediatrics, University of Pennsylvania School of Medicine, Philadelphia, has been presented the 1956 Ciba award of the Endocrine Society for outstanding research in human endocrine glands.

Dr. Bongiovanni worked on the chemical nature of adrenal cortex horomes and on the abnormalities in the biosynthesis of these hormones which lead to various adrenal diseases.

The award is made annually to a scientist under 35 years of age. It provides $1,800 plus $700, for expenses should the winner decide to move to a laboratory other than his own.

American Dietetic Association To Convene in October

Milwaukee will be the scene of the American Dietetic Association's 39th annual meeting, October 9-12.

Experimentation in the use of antibiotics on meat will be reported during a food technology session, by Vern R. Cahill, Ph.D., assistant professor, animal science department, Ohio State University.

Olaf Mickelsen, Ph.D., will discuss "Is Toxicology Enough in a Food Protection Program?" Mickelsen is assistant chief, laboratory of nutrition and endocrinology, Institute of Arthritis and Metabolic Diseases, National Institutes of Health, Bethesda, Md.

Sanitation will be the subject of W. L. Mallman, Ph.D., professor of bacteriology, Michigan State University.

Topics of other speakers include nutrition research, nutritional deficiency diseases, and "Treatment of Diabetes Mellitus with Oral Sulphanamide Compounds."

Dr. Wilinsky Receives AHA Service Award

Recipient of the 1956 AHA Distinguished Service Award is Charles F. Wilinsky, M.D., former executive director, Beth Israel Hospital, Boston.

Dr. Wilinsky will receive the award, highest honor conferred by the association, at the AHA convention in Chicago this month.

A leader in hospital administration and public health work, Dr. Wilinsky is the only person to have held the presidencies of both the AHA and the American Public Health Association.

Chicago Hospitals Studied By Management Group

The Chicago Hospital Council and [illegible] Chicago chapter, Society for Advan[illegible]ment of Management, are cooperat[illegible] in a program designed to help ho[illegible]tals to adapt modern business m[illegible]agement technics to their operat[illegible]

The program is similar to those [illegible] being operated by the SAM in N[illegible] Brunswick, N. J., Detroit, and oth[illegible] areas.

Management engineers employed [illegible] local industries are conducting pr[illegible]ects in the following hospitals:

Presbyterian-St. Luke's (west s[illegible] branch): Cost studies in selected h[illegible]pital departments, to develop m[illegible] effective methods of allocating co[illegible] (by the cost accounting divisi[illegible] Johnson & Johnson).

Mount Sinai: Study of possible wa[illegible] to speed up admission procedures ([illegible] the systems and procedures depa[illegible]ment, Alden's, Inc.).

Norwegian-American: Study of wa[illegible] to improve hospital safety progra[illegible] (by the safety director, Chicago offi[illegible] Eastman Kodak).

University of Illinois Researc[illegible] Work simplification training progra[illegible] for management and supervisory pe[illegible]sonnel (by Sears, Roebuck and Co[illegible]

Results of these and similar studi[illegible] will be distributed to other hospita[illegible]

THE *Steriphane* SYSTEM

NEW, MODERN TECHNIQUE FOR PROCESSING HYPODERMIC NEEDLES SYRINGES AND CATHETERS

Write for brochure giving complete information of this "Hospital Accepted" Technique.

Visit Our Booth No. 270 at the A.H.A. Convention For A

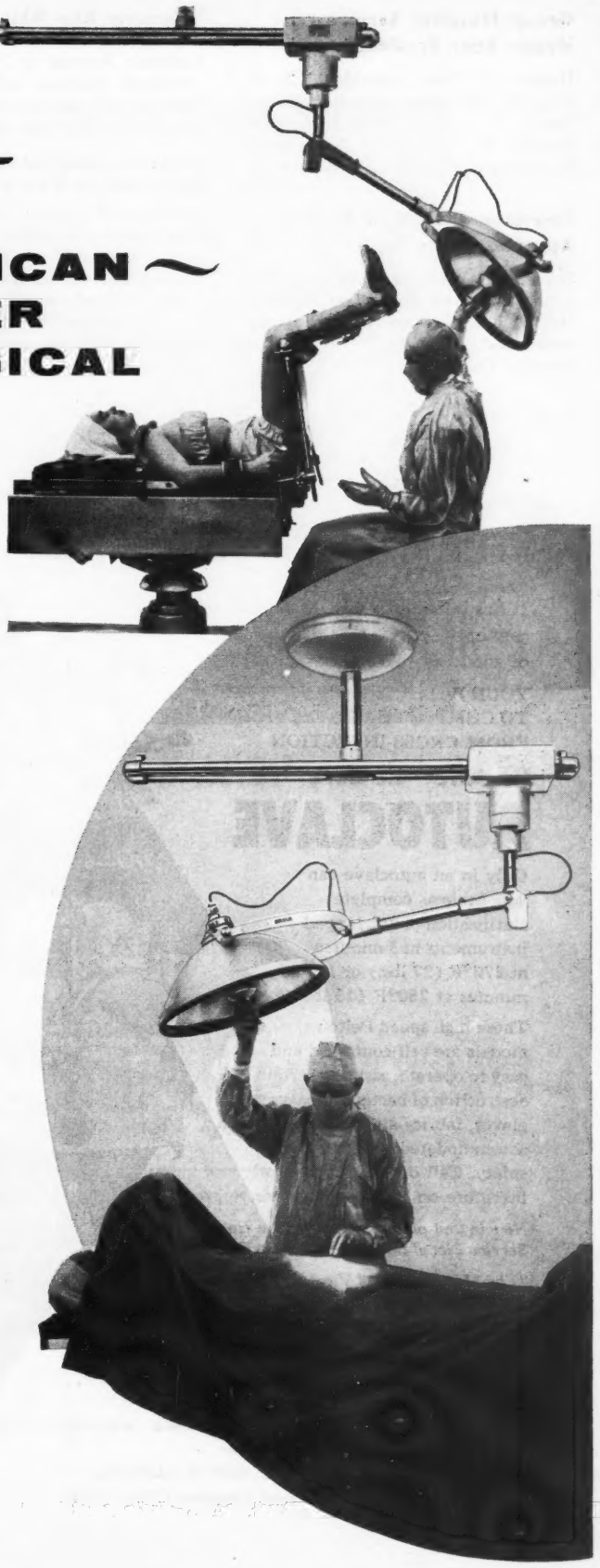
DEMONSTRATION

SERVING INSTITUTIONS SINCE 1922

HAROLD SUPPLY CORPORATION

Now—

FROM AMERICAN ~ 22" DIAMETER MINOR SURGICAL LIGHTS . . .



Superior illumination for all obstetrical and lesser surgical procedures . . . with ample scope for the unanticipated major procedures which may be encountered.

FEATURES

- 22" reflector gives greater shadow reduction.
- A selection of light patterns accommodates large incision as well as minute opening surgery.
- Sterilizable control handle permits surgeon to direct his own light beam during procedures.
- Greater degree of illumination is provided by improved optical system . . . up to 6000-foot candles in the small pattern.
- Open reflector saves weight of door glass and is more easily kept clean.
- Can be supplied with Variac Control if light intensity regulation is desired.

Amsco catalog number C-123 illustrates seven models in the new 22" series as well as portable, explosion-proof luminaires. Write for a copy.

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

Group Hospital Service Names Baer President

Howard F. Baer, president, A. S. Aloe Co., has been elected president, board of trustees, Group Hospital Service, St. Louis Blue Cross plan. He succeeds William C. B. Sodemann.

American Journal of Nursing Appoints White Editor

Jeanette V. White has been appointed editor, *American Journal of Nursing*. Nell V. Beeby, former editor, will become chief executive, the Journal of Nursing Co.

Formerly Miss White was managing editor, *Nursing Outlook* and the *American Journal of Nursing*.

Mildred Gaynor, editor, *Nursing Outlook*, will become managing editor, *Nursing Outlook* also.

Evanston Hospital Honors Employees in Award Ceremony

One hundred forty-six employees who have served Evanston (Ill.) Hospital for five to over 40 years were recently honored at a service award ceremony.

Mrs. Elizabeth Kidnay, sewing room supervisor for more than 40 years, received the special service pin studded with two diamonds.

HEPATITIS*...in your office?

It has been estimated that up to 6 per cent of the population may be carriers of virus B (serum hepatitis).†

YOUR PATIENTS ARE ENTITLED TO COMPLETE PROTECTION FROM CROSS-INFECTION

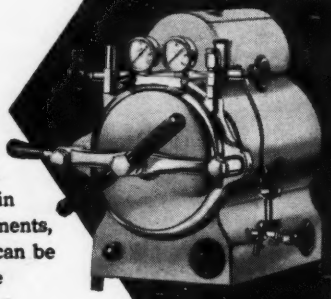
Be Safe—Be Sure

AUTOCLAVE

Only in an autoclave can you achieve complete sterilization of unwrapped instruments in 3 minutes at 270°F (27 lbs.) or 10 minutes at 250°F (15 lbs.).

These high speed Pelton models are self-contained and easy to operate, assuring certain destruction of bacteria. Instruments, gloves, fabrics and solutions can be accommodated with complete safety. Call or write today for literature on Pelton autoclaves.

(FL2—6" x 12" chamber)



(HP-2—8" x 16" chamber)

Also Model LV-2 12" x 22" chamber

*Now in 2nd place on U. S. Public Health Service List of Selected Notifiable Diseases.

†"The Management of Viral Hepatitis," by Hyman J. Zimmerman, M. D., Journal of American Academy of General Practice, June 1955

the Pelton & Crane company

CHARLOTTE 3, NORTH CAROLINA

Fine Professional Equipment Since 1900

Professional and Hospital Activities Commission Formed

The American College of Surgeons, American Hospital Association, American College of Physicians, and Southwestern Michigan Hospital Council recently organized the Commission on Professional and Hospital Activities.

The commission has received a grant of $260,000 from the W. K. Kellogg Foundation to support the program for three years. The commission is an outgrowth of the professional activity study carried on for the last three years.

The commission will conduct a medical statistical service that will help hospitals simplify medical records and analyze records more effectively for improvement of medical and administrative practices.

VA Plans Increased Medical Research

An enlarged medical research program will be conducted by the VA with the $10,000,000 Congress appropriated for fiscal 1957, beginning July 1, 1956. This is $4,300,000 more than was appropriated last year.

Most of the increased medical research will be concentrated in mental, nervous, and brain diseases, heart and artery diseases, cancer and leukemia, and problems of aging.

VA also will expand its research program in tuberculosis, fungus diseases resembling TB, and infectious diseases.

Cooperative Study Planned Of Long Term Diseases

A cooperative arrangement between Edgewater Hospital, Chicago, and Fox River Tuberculosis Sanitarium, Batavia, Ill., has been developed for management and treatment of diseases of the chest, heart disease, and cancer.

A medical team of Drs. Philip Kaplan, Edwin R. Levine, Hyman L. Sapoznik, and Louis Savitt developed the proposed program, which includes the following:

Treatment: Fox River patients will be transferred to Edgewater Hospital for surgery or if the disease enters an acute stage.

Investigation and Study: Research into new methods and medicines, and better methods of treatment of long-term diseases with available facilities.

Education: Instruction and experience in management of long-term diseases.

The 300-bed Edgewater Hospital and 50-bed Fox River Sanitarium will have a single medical staff.

Will infection develop here?

If the operating team scrubs up with pHisoHex and the patient's skin is "prepped" with pHisoHex, postoperative infection rates can be reduced as much as 75 per cent.[1]

pHisoHex preoperatively ensures "... a greater degree of surgical cleanliness ... than that possible through the use of any other detergent."[2] pHisoHex provides increased safety to the surgical patient—smooths the postoperative course.[3]

In 6242 operations by general surgeons, use of pHisoHex set an all-time low in postoperative infections of only 1.2 per cent.[4]

Bactericidal pHisoHex (detergent emulsion containing 3 per cent hexachlorophene) prolongs antisepsis, makes skin virtually sterile in constant users.

Winthrop LABORATORIES
New York 18, N. Y. Windsor, Ont.

1. Freeman, B. S.; and Young, T. K., Jr.: *Arch. Surg.*, 61:1145, Dec., 1950. 2. Shay, D. E.: *Oral Surg., Oral Med., & Oral Path.*, 4:355, Mar., 1951. 3. Canzonetti, A. J.; and Dalley, M. M.: *Ann. Surg.*, 135:228, Feb., 1952. 4. Bowers, R. F., in discussion of Price, P. B.: *Ann. Surg.*, 134:476, Sept., 1951.

pHisoHex, trademark reg. U. S. Pat. Off.

pHisoHex®
nonirritating, hypoallergenic

WINTHROP LABORATORIES
1450 Broadway
New York 18, N. Y.

Gentlemen:
Please send me instruction pads for patients on bathing daily with pHisoHex® for 5 days prior to surgery.

..... M.D.
..... STREET
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1094M

TRADE TOPICS...

At a recent hospital sales meeting in Highland Park, Ill., Bauer and Black hospital specialists and sales managers (shown above) discussed new sales, product and advertising programs. Promotional programs were presented and illustrated.

Crescent Metal Products Names Sales Manager

Crescent Metal Products, Inc., has appointed John Phelps as sales manager. He will make his headquarters in Cleveland.

Parmacel Tape Buys LePage's Inc.

Parmacel Tape Corporation, New Brunswick, N. J., recently purchased LePage's, Inc.

Parmacel acquired control of the stock, in accordance with an offer made to LePage shareholders through the LePage management.

LePage's, Inc. will continue as a separate company with its own management.

John Jones Sales Manager At Pioneer Rubber Co.

John R. Jones has been appointed sales manager, Pioneer Rubber Co. Formerly he was field sales manager, sundries division, B. F. Goodrich Co.

Gilbert Hyde Chick Announces Changes

William B. Peele has joined the Gilbert Hyde Chick sales forces serving the midwest territory.

Jim Mahan will cover northern California and Nevada, with headquarters in San Francisco.

Frank S. Gribble, Jr. has been transferred to Atlanta to assist Zack Rogers, general sales manager.

Consulting Engineers Firm Opens Cleveland Office

Scanlan - McMahon Associates, Inc. has established an office in Cleveland, to be staffed by Thomas R. Scanlan and James F. McMahon, Jr.

Both have had experience in design, installation, and operation of industrial process and steam power plant equipment.

Ritter Company Appoints Alexander

H. W. Alexander has joined the Ritter Co. as manager of lighting research and development. He formerly served as director of surgical lighting research and development, American Sterilizer Co., Erie, Pa.

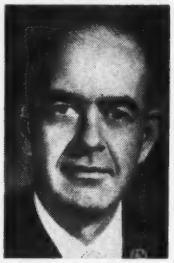
News Briefs

A. L. Ross has been promoted to sales manager, Wyeth Laboratories overseas affiliate, with headquarters in Radnor, Pa. Formerly he was assistant sales manager. **Eugene B. Goodman** has been appointed promotion manager, Wyeth International Limited, Inc. He will have direct supervision of advertising, sales training, and sales promotion.

Lehn & Fink Appoints Southeastern Man

Warren Reid has been appointed southeastern representative for Lehn & Fink Products Corp. He is replacing Charles Manz, who has been transferred to Los Angeles.

General Sales Manager for Mead Johnson & Co.

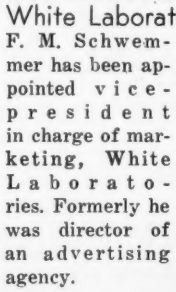


Rhoades Alderson has been appointed general sales manager, of Mead Johnson & Co.'s parenteral products division. Formerly he was eastern field sales manager.

New Assistant Sales Manager At C. B. Fleet Co., Inc.

William P. Ferrell has been made assistant sales manager, C. B. Fleet Co. Inc. Formerly he worked the Boston-New England territory.

William Vandergriff Named to Sales Staff



J. A. Deknatel & Son recently appointed William Vandergriff to its western sales staff which includes northern California and certain parts of Washington and Oregon.

New Vice-President for White Laboratories

F. M. Schwemmer has been appointed vice-president in charge of marketing, White Laboratories. Formerly he was director of an advertising agency.

Mr. and Mrs. Nelson Schoenfeld (r.), owners, Budget Uniform Center, Philadelphia, bid good-bye to Mr. and Mrs. Richard Barrett (l.), San Jose, Calif., as they leave for a one-month all-expense paid tour of Europe. Mrs. Barrett won the trip as first prize over 15,000 other contestants, in a limerick contest sponsored by the company. She is a nurse at the Santa Clara (Calif.) County Hospital.

Reed & Carnrick Adds Detail Men

Jesse Feinberg has been appointed to represent Reed & Carnrick in Brooklyn and Manhattan area.

Murray Moskowitz will cover the Bronx and Westchester county, and Irving Yablonsky will cover Pennsylvania and northern New Jersey.

David J. Byrnes has been appointed to represent J. A. Deknatel & Son Inc. in Michigan and Ohio.

Parke, Davis & Co. Promotes Six Men

Six Parke, Davis & Co.'s representatives have been promoted to the firm's Hospital Medical Service Division under the direction of Donald A. Swanson.

The six include: L. W. Kooistra and M. K. Schroeder, the Chicago area; R. L. Macke, New Orleans, La.; G. E. McPhee, San Francisco, Calif.; F. D. Kincaid, Seattle, Wash., and J. W. Richardson, Portland, Ore.

Ethicon to Distribute Fenwal Labs Products

Ethicon, Inc., Somerville, N. J., has completed arrangements to assume exclusive distribution of medical products of Fenwal Laboratories, Inc., Framingham, Mass.

Chief product line includes the components of a system for collection, processing, storage, and infusion of blood in plastic equipment.

The all-plastic system was developed at Peter Bent Brigham Hospital, Boston. Blood stored in plastic containers does not deteriorate as rapidly as when stored in glass.

Jack J. Begley has been named vice-president in charge of manufacturing, Colson Corp. Formerly he was assistant to the president, Colson Corp.

★ ★ ★

Abraham Mittelmark has been appointed assistant to the medical director, Eaton Laboratories. He will assist **Boris Anzlowar,** medical editor, in scientific literature research on the nitrofurans, antimicrobials developed for human and veterinary medicine.

Becton, Dickinson and Co. Opens Brazilian Plant

Becton, Dickinson Industrias Cirurgicas, S.A., the South American subsidiary of Becton, Dickinson and Co. opened a new syringe manufacturing plant north of Rio de Janeiro.

Attending the company's ceremony were the Minister of Health, representing Brazilian president Juscelino Kubitschek; Governor Bias Fortes of the State of Minas Gerias; and Romeu do Carmo Abreu, director-president of the plant.

White Knight Mfg. Co., Ozark, Ala. has completed a new building which doubles former plant capacity for manufacture of hospital garments.

Permanent **KWIKSORT** *Markings are exclusive with* **MATEX** *and* **MASSILLON** *Latex Gloves*

EXCLUSIVE—Matex (white) and Massillon Latex (brown) surgeons' gloves are the only gloves that carry the permanent, indestructible Kwiksort size markings.

LABOR-SAVING—Distinctive Kwiksort size markings speed sorting and pairing — cut labor costs.

And Kwiksort markings identify the gloves that provide comfortable fit, bare-finger tactility and long, long life.

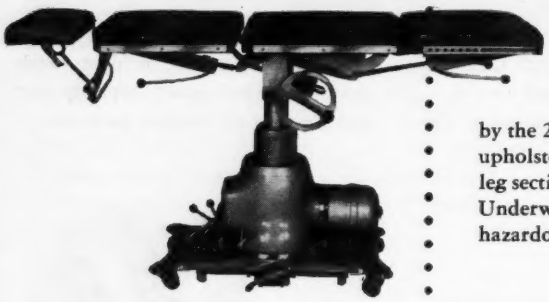
Ask your surgical supply dealer—he'll tell you why leading hospitals use MATEX and MASSILLON Latex.

THE MASSILLON RUBBER COMPANY
Massillon, Ohio

Hospitals GAIN INCREASED FLEXIBILITY...

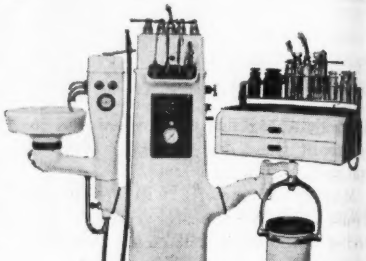
GREATER EASE OF OPERATION with

Ritter Equipped Treatment Rooms



Ritter ENT and Emergency Surgery Table, 9-S-21

A touch of the toe smoothly raises or lowers this table . . . its 4-section top is quickly and easily adjustable to the positions required. Maximum patient accessibility is offered by the 20-inch top width. Table is equipped with static conductive upholstery, mobile base and floor lock, side rails on back, seat and leg sections. The exclusive Ritter motor-hydraulic base is approved by Underwriters' Laboratories, Inc., and C.S.A. for use in hazardous locations, Class 1, Group C.

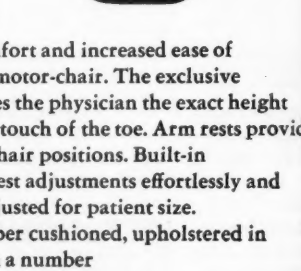


Ritter ENT Unit, Model MA, Type 1

All five essentials for ENT work are within easy reach . . . air, water, vacuum, electricity and waste. Major low voltage instruments, spray bottles and medicaments are conveniently located for increased efficiency. Swinging instrument table, including special spray and suction bottle, is moved into the physician's working area by a mere touch of the fingers. Your choice of a Ritter ENT Unit provides your hospital with complete facilities for thorough examination and treatment.

Ritter Motor Chair, Model MC

Modern styling, greater patient comfort and increased ease of adjustment keynote the new Ritter motor-chair. The exclusive Ritter motor-hydraulic base provides the physician the exact height desired from 20 to 38 inches, with a touch of the toe. Arm rests provide comfortable patient support in all chair positions. Built-in spring compensation permits backrest adjustments effortlessly and quickly; chair arms can be easily adjusted for patient size. Back and seat sections are foam rubber cushioned, upholstered in top-grain leather. Chair is offered in a number of attractive colors.

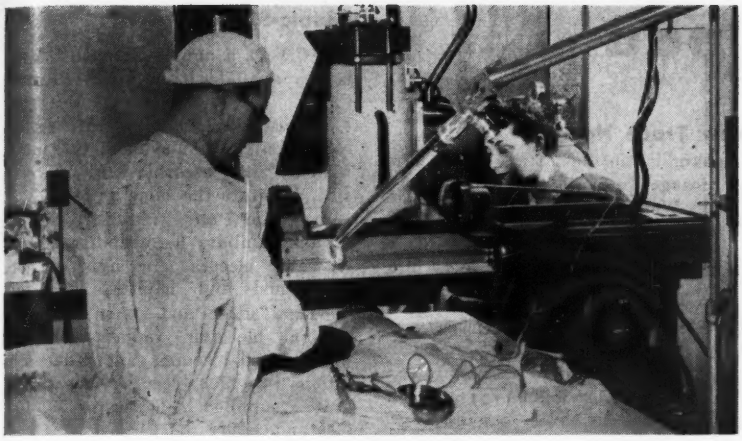


Ritter ENT-ORAL and DENTAL SURGERY Unit

Many hospitals and clinics require only the part time services of an Ear, Nose and Throat Specialist and Oral Surgeon. By using a Ritter ENT Unit, equipped with a Ritter Dental Engine, the small hospital is provided with an ideal combination. All the essentials for Ear, Nose and Throat work, oral and dental surgery are present. This arrangement provides all these facilities at a minimum cost and considerable saving of space. Each specialist is able to use this equipment part time to great advantage.

WRITE for additional information to the Ritter Company, Inc., 5421 Ritter Park. Rochester 3, N.Y., U.S.A. . . . or contact your Ritter dealer. The Ritter Company, through its dealers, will be glad to assist in the planning of treatment rooms and equipment installations.

Ritter Company Inc.



Closed-circuit television has cut the time for heart catheterization operations at the Cleveland Clinic 20 to 30 percent by making it possible for the doctor to look at a life-size view of the heart. Pictured above F. Mason Sones, Jr., M.D., who conceived the TV system with the Clinic's chief radiologist, Robert Hughes, M.D., performs heart catheterization operation on three-month old baby. Nurse Shirley Koehler assists.

The Dage-TV camera focuses on small light-intensified image from fluoroscope and transmits it to easily-seen large-screen monitor across the table from doctor.

SCANNING

(Continued from page 7)

Artificial Heart-Lung Machine Successful at Duke Hospital

Five operations utilizing a new heart-lung device have been reported at Duke Hospital, Durham, N. C.

The new oxygenator used is said to take over the work of the heart and lungs more efficiently and with less danger to the patient than any previously reported device.

Lowering of body temperatures about 12°F. before operation was also used by Duke surgeons for the first time in combination with an artificial heart-lung.

Four child and adult patients with congenital heart defects were operated on successfully with the heart-lung in use for as long as eight minutes during each operation.

The fifth patient, a two-month-old baby, required the use of the heart-lung for two and a half hours, but its defect could not be remedied surgically. The baby survived.

Stanford University Plans New Medical Center

The $21,950,000 Stanford Medical Center Fund recently announced by former President Herbert Hoover is the largest effort of its kind ever undertaken in the West.

Objective is to construct a medical center on the university's campus at Palo Alto, Calif. The goal includes $1,000,000 for improving the present Stanford Hospital in San Francisco.

The group of three-story buildings planned for the center will contain a 215-bed teaching hospital, clinics, teaching facilities, and a library. Construction of the first unit will begin this fall.

These buildings, to comprise approximately 525,000 square feet, will be erected at a cost of $14,450,000. The campaign seeks endowment funds of another $6,500,000, plus the $1,000,000 for improving the Stanford Hospital in San Francisco.

Additional teaching facilities will be afforded by a 1,000-bed VA Hospital to be built on Stanford land near the proposed medical center.

Announce National Hospital Week Pharmacy Award Winner

The American Pharmaceutical Association's award for the best hospital pharmacy display during National Hospital Week has been awarded to Frank F. Stencil, Montefiore Hospital, Pittsburgh, Pa.

The plaque will be presented to Mr. Stencil at the annual meeting of the American Society of Hospital Pharmacists, to be held in conjunction with the American Pharmaceutical Association convention in New York City the week of April 28, 1957.

Two Leaders in Nursing Receive Awards

A highlight of the recent Pennsylvania Nurse Week was the presentation of awards to two outstanding individuals in the field of nursing.

Recipients of the plaques were Fannie W. Eshelman, R.N., director of nursing, Henry Phipps Institute, Philadelphia, and LeRoy N. Craig, director, Men's School of Nursing, Pennsylvania Hospital, Philadelphia.

Blue Cross Revises National Structure

Activation of the Blue Cross Association as a national enrollment force was approved at a recent meeting of Blue Cross Plans in Chicago, after two years' study.

The Association was first organized in 1948 as a framework for Health Service, Inc., stock insurance company performing an underwriting service for Blue Cross.

The revised Association, directed by a board of governors elected by a mail vote of approved Blue Cross plans, will write service contract benefits. Participating plans will provide the services locally.

The Association is entirely separate from the Commission, whose relationship to the American Hospital Association remains unchanged.

Tri-State Hospital Assembly Amends By-Laws, Elects

A major reorganization of the Tri-State Hospital Assembly provides for continuity in representation of the four participating state associations, Illinois, Indiana, Michigan and Wisconsin, by annual election of the four major offices.

The Board elected the following officers: Leonard W. Hamblin, administrator, Blessing Hospital, Quincy, Ill., and current president, Illinois Hospital Association, president; A. C. Kerlikowske, M.D., director, University Hospital, Ann Arbor, Mich., vice-president; Sister Mary Reginald, R.S.M., Dyer, Ind., secretary; Riley McDavid, administrator, Kenosha (Wis.) Hospital, treasurer.

Albert G. Hahn, L.H.D., administrator, Protestant Deaconess Hospital, Evansville, Ind., was appointed executive director and Mrs. Hahn was named associate executive director. Program director is Leo M. Lyons, Chicago.

Exhibits and all other organizational activities will be Dr. Hahn's responsibility, while program and local convention arrangements will be handled by Mr. Lyons' office at 105 W. Adams St., Chicago 3.

Tri-State will have a 16-member board of directors, four from each participating state.

prescription pad

Aid to Obese

Preludin (Geigy) is a new product designed to reduce food intake in overweight patients.

It is an anorexigenic agent containing 2-phenyl-3 methyl-tetrahydro-1, 4-oxazine hydrochloride, a white water-soluble crystalline powder. Preludin is said to reduce food intake by causing earlier appeasement of appetite with lesser caloric intake. Side effects are few, according to the manufacturer.

The 25 mg. tablets are supplied in bottles of 100, available only on prescription.

Senokot in Tablet Form

Senokot, for correction of constipation, is now available in tablets, the Purdue Frederick Co. has announced.

The medication is derived from an extract of the pod of Cassia acutifolia (North African senna).

Tablets are packaged in bottles of 100.

Relief of Narcotic Depression

Lorfan Tartrate has been introduced by Hoffmann—La Roche Inc. for combatting narcotic-induced respiratory depression.

It is said to relieve respiratory depression without affecting analgesia—usually within one minute. The effect lasts two to five hours. It does not affect types of respiratory depression not due to narcotics.

Lorfan Tartrate is available in a parenteral solution containing 1 mg. per cc. of 1-3-hydroxy-N-allylmorphinan tartrate. It is packaged in 10-cc multiple-dose vials.

Antibiotic for Resistant Strains

Cathomycin (novobiocin Merck), an antibiotic for treating infections caused by certain bacteria that have become resistant to other antibiotics, is now available from Sharp & Dohme Division, Merck & Co.

Clinical trials indicate the antibiotic's effectiveness against infections and certain urinary tract infections caused by Proteus vulgaris, the manufacturer reports. Its usefulness against other infections is being evaluated.

Effective antibacterial levels are said to be attained in the blood stream within one to two hours, and maintained with doses given four times per day.

New Trade Name

Lanoxin is the new trade name for all dosage forms of Digoxin (Burroughs-Wellcome), as of August 1.

The new name was adopted to clarify the distinction between Digoxin and Digitoxin products.

Salicylate Tablet

Ascriptin (Rorer) is a new salicylate tablet which is said to attain higher blood plasma levels than plain or buffered aspirin, with rapid, more prolonged action.

Disintegration is rapid, and gastric irritation rare, according to the manufacturer.

Each tablet contains 0.30 gm. of acetylsalicylic acid and 0.15 gm. of magnesium aluminum hydroxide. Tablets are supplied in bottles of 100 and 500.

Control of Cough

Consol, a new antitussive-expectorant from the Merrell Co., contains narcotine, an antitussive which is non-habit-forming but as potent as codeine and free from side-effects, according to the manufacturer.

Each 5 cc. (one teaspoonful) contains 5 mg. narcotine, 50 mg. terpin hydrate, and 3 mg. decapryn (doxylamine) succinate, in a thixotropic suspension containing mild menthol and 1.3 percent alcohol. Consol comes in 4 and 16-oz. bottles.

Reserpine Tablets

Renir, a new hypotensive-tranquilizer which is said to maintain the desired blood-pressure lowering effect of reserpine while minimizing side reactions, has been released by the Massengill Co.

Suggested dosage is one to three tablets daily for hypertension; as a tranquilizer in mentally disturbed states, two to four tablets daily. Tablets are supplied in bottles of 100.

Lipiodol Diagnostic

Visciodol, a new oily suspension for use in brochography, is available from E. Fougera & Co.

It is a suspension of finely divided sulfanilamide in Lipiodol 40 percent. Visciodol, because of its higher viscosity, is said to penetrate the bronchi much more slowly, and rarely to penetrate the alveoli.

It is almost completely eliminated within a few days, is bland and non-irritating, and has the same high radiocontrast density as Lipiodol. It is supplied in 15-cc. vials.

Double-Strength C.V.P.

Duo-C.V.P., a double-strength C.V.P., is now available from U. S. Vitamin Corp.

It provides 200 mg. of water-soluble citrus bioflavonoid compound with 200 mg. ascorbic acid per capsule. Uses are the same as for C.V.P. —prevention and treatment of abnormal capillary permeability, fragility and bleeding in hypertension, threatened and habitual abortion, duodenal ulcer and other gastrointestinal bleeding, radiation injury, postsurgical bleeding, and other conditions in which bleeding may occur.

It is supplied in bottles of 50, 100, 500 and 1,000.

Renoquin Lotion

Renoquin lotion is a companion product to the more concentrated (20%) Renoquin ointment for the topical treatment of hyperpigmentation.

The lotion, a 5% purified monobenzyl ether of hydroquinone (monobenzone, Elder) in an isopropyl alcohol-propylene glycol vehicle, is specially recommended by the manufacturer for severe freckling, lentigines, and the more diffuse types of hyperpigmentation such as chloasma.

It is supplied by the Paul H. Elder Co. in 4-oz. bottles.

For Treatment of Diarrhea

Pomalin, for treatment of the infectious diarrheas, has been introduced by Winthrop Laboratories. It is also suggested for use in functional diarrheas and following the use of antibiotics.

The product is a flavored suspension containing in each 15 cc. sulfaguanidine (2 Gm.), pectin (0.225 Gm.), kaolin (3 Gm.), and opium tincture (0.08 cc. equivalent to 2 cc. paregoric).

Pomalin is available in 16-oz. bottles.

New Nasal Spray

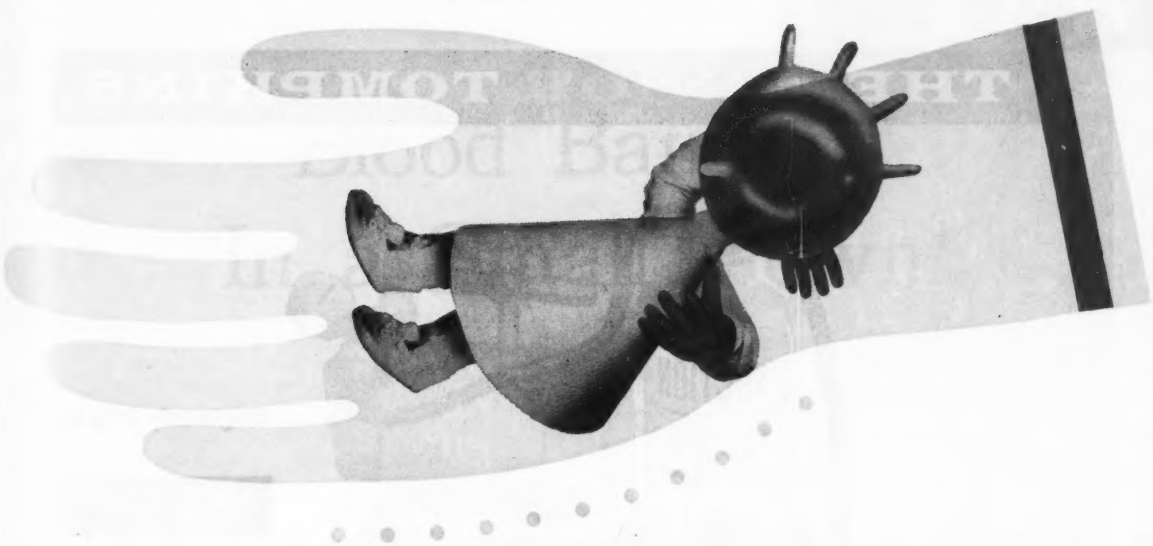
Neo-Delta-Cortef, 0.1%, nasal spray, for the relief of symptoms of inflammatory nasal conditions due to hay fever, colds or nasal polyps associated with hay fever, is being marketed by The Upjohn Co.

Each cc. contains: delta-1-hydrocortisone, 1 mg. (0.1%); neomycin sulfate, 5 mg., and phenylephrine hydrochloride, 2.5 mg., preserved with myristyl-gamma-picolinium chloride: 1:5000.

The spray is supplied in 15-cc. plastic spray bottles.

(Continued on page 121)

curved for greater comfort



the curved finger story

WILSON surgeons' gloves

In ordinary, straight-fingered surgeons' gloves, the glove may work *against* the hand. For every movement requiring flexion, greater than normal effort is needed. Tension and finger fatigue result.

To overcome this problem, WILSON research and production experts developed the WILSON *curved finger* glove—a glove whose shape conforms to the natural, curved contour of the relaxed hand. The result: operating room personnel using WILSON Surgeons' Gloves report greater ease and freedom of movement than ever before, and a striking reduction in hand and finger fatigue.

COLOR-BANDED FOR QUICK SORTING

THE WILSON RUBBER COMPANY B-D

A DIVISION OF BECTON, DICKINSON AND COMPANY • CANTON, OHIO

B-D AND WILSON, T.M. REG. U.S. PAT. OFF. 34655

Now...A Really PORTABLE Aspirator

THE JUNIOR TOMPKINS

Weighs only 16½ lbs.

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Complete with Yankauer suction tube and utility wrench

Cat. No. 100-65

COMPARE THESE FEATURES

- Totally enclosed heavy duty motor... requires no lubrication... rubber mounted to insure quiet, vibrationless operation
- 32 oz. suction bottle
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Perfectly balanced... easy to carry

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Sklar Equipment is available through accredited surgical supply distributors

Blood Banking In a Small Town*

By O. Van der Velde, M.D.

• The ready availability of whole blood and blood derivatives has become a vital part of modern medical practice. Their use should become the prime concern of every physician not only in large cities but also in every small community. Hence, it is our belief that every hospital, large or small, should have whole blood available for immediate call.

Holland, Michigan, is an average small American city with a population of 17,000, but it serves a trading area of 40,000 people. Perhaps it is better known to most people for its tulips. However, it is likewise known throughout Michigan and many areas of the midwest for the excellence of its whole blood program. It is given the credit for stimulating the origin of the incomparable plasma and blood derivatives program of the Michigan State Health Department.

There are 110 available hospital beds in the area plus an additional 80 beds under construction. Our blood program is operating in its eighth year. Our experience has been happy, and the program is a hallmark in the community. This is the story of the program.

In February, 1948 the American Red Cross opened its first regional blood center in Rochester, New York, and the plan was to open similar regional blood centers throughout the nation. Our community was included in the early plans.

We had donated blood liberally to mobile collecting units during the years of the emergency. Our people had some knowledge of the use of whole blood in war, but little knowledge of its use in civilian life. The Dutch people are a deeply religious, conservative race who believe that the Lord helps those who help themselves. Our doctors were anxious to avail themselves of a good blood program, but it was thought that our people would support a purely local program far more enthusiastically than one in which strangers came in and took the blood away to some distant center for distribution.

Accordingly, we asked the Red Cross to help us initiate a purely local chapter program on a strictly community level. After due consideration the Red Cross decided to help us in a pilot or "permissive" program—as they called it. To my knowledge Holland was the first small city to build a blood program of this nature.

Naturally, we had to do a lot of pioneering, since we had little to guide us at the time. We realized early that blood banking is a medical function and should remain as such. However, we also realized early that without the wholehearted support of our people, we would fail in our efforts. Any blood program must live by its donors. Unless there is created in the people a desire to give blood, a small community blood program will fail. Upon these facts we proceeded to build.

The program was initiated by the county medical society. It was agreed that the local chapter of the Red Cross would conduct the donor program under the sole direction of the physicians, and the entire organization would be under a medical director. We enlisted the cooperation and support of the county health unit, the county nurses' association, the hospitals, all civic organizations, the local press, and — most of all — the people.

Five months were spent in organizing and in educating the community as to the purpose and needs of a successful program. Every medium available for reaching the public was used — newspapers, radio, movie shorts, billboards, and personal appearances before all groups such as civic clubs, church groups, PTA's, and labor unions.

A donor center on a production line basis was set up in the Red Cross quarters and staffed by a capable group of volunteer workers. The donor center occupies five rooms—a waiting room, a history room, a room for temperature and hemoglobin determinations, a donor room, and a canteen.

The first donor clinic was held July 15, 1948. At that time, the blood needs were about 30 units a month; accordingly, a donor clinic was held every two weeks on Monday evening between the hours of five and seven. It requires 16 workers to man each donor clinic; two receptionists, two historians, one technical worker to determine temperatures and hemoglobins, five trained nurses and two physicians, two nurses' aides to label and pack the blood in iced containers for transportation to the hospital blood bank, and two women in the canteen. About 200 volunteers are working in the program. Schedules

(Continued on next page)

*Reprinted by permission from the **Bulletin, American Association of Blood Banks,** April, 1956. Dr. Van der Velde is from the Holland (Mich.) Community Blood Bank.

satisfactory to surgeon and budget

The surgical staff's most exacting demands are satisfied by the keener edge, better balance and greater weight of Crescent Blades.

The budget benefits by savings of up to one-third made possible by Crescent Blades.

TRY before you BUY. Send for free sample.

Crescent Surgical Sales Co., Inc.
48-41 Van Dam Street
Long Island City, New York

Crescent
surgical blades and handles

for volunteers are set up a year in advance.

All donors are given a glass of fruit juice prior to donation and coffee and sandwiches afterwards. Everything is done to make the experience as pleasant as possible for the donor so that he will want to come back and also report favorably to others about us.

At the end of each clinic a police cruiser is dispatched with blood to the hospital, where it is processed and stored for immediate use. The Red Cross is responsible for the entire donor recruitment program and its cost. The hospital is responsible for the processing, storage, and plasma program. Plasma from outdated blood is recovered, frozen in two-gallon bottles, and shipped to the Michigan State Health Department for further processing. These products are then returned to us free of charge for use in the hospital.

At the present time we are collecting about 1,500 units a year. Table 1 outlines the costs of this program, which are $1.34 per unit to the Red Cross and $5.47 to the hospital, or a total of $6.81 per unit to the community. In addition, the hospital makes an administration charge of $6.00 per unit to the recipient.

Besides providing all blood requirements in three hospitals, blood is replaced for any county resident in any hospital within the state or outside the state through a working agreement with the Lansing Red Cross Regional Blood Center.

Between 85 and 90 percent of our donors are replacements. The remainder are reliable regular donors who are proud of their gallon buttons. We have learned that people will gladly donate their blood if they know that no one is making a profit on it.

Occasionally, a donor who has been spoiled by a $25 fee in a large city wants to sell blood. He is told simply that we do not buy or sell blood. However, our people know that there is no such thing as "free blood," since the charges for collection and administration are explained clearly. They also know that they are getting blood at cost and that no one makes a cent on any of it.

Recently, one of our residents had major surgery in a large midwestern clinic. She received 28 units of plasma and ten units of blood. The husband, who is an ordinary factory worker, was presented with a bill of $1,200 for the blood and plasma. All of the blood for this patient was replaced, and this man was relieved of a heavy financial burden. This is the kind of service our blood program is giving our people. After eight years, is it any wonder that the program is supported?

The requisites of a successful whole blood program in a small town are:

1. The entire program must be guided and administered by the local medical profession.
2. The public must be educated as to the value of the program and given an active part in the program. There are many tasks in the recruitment of donors and conduct of donor clinics that volunteer workers can do.
3. Blood costs must be kept within the reach of every man's purse.
4. Every small-town blood program must be tailored to fit each particular community. A uniform national plan for all communities is impractical, but in general, our program may serve as a model for other small American cities. What Holland, Michigan, is doing with its blood program can be done in any other small community.

Table 1. Cost per unit of blood

Hospital cost of processing and administration	
Laboratory work	$3.18
Bottle—150 cc normal saline	.60
One double recipient set	.89
Disposable needle for set	.05
Labor—setting up and starting blood	.75
Total hospital cost	$5.47
Red Cross cost of recruiting and collecting blood	
Collection bottle	.27
Donor set	.52
Food	.24
Other expense	.31
Total Red Cross cost	$1.34
Total cost per unit	$6.81

SEPTE

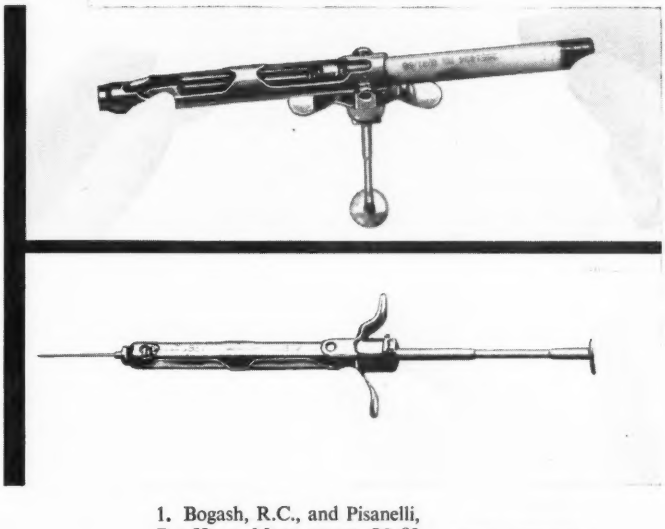
Conclusive evidence[1,2,3]

Your Hospital Profits from

CLOSED-SYSTEM INJECTION

- *No hidden costs*—no sterilization, no needle-sharpening, no syringe breakage, no dose preparation, no unused medication
- Presterilized—asepsis assured
- Ready to use, *easy* to use
- Precision medication—accurate dose
- Every injection with a new needle—minimizes pain, eliminates wasteful routine
- Reduced risk of infectious hepatitis
- Reduced risk to personnel of contact sensitization
- Simplified supply handling and accounting control

TUBEX brings the full advantages of the closed-system technique to hospital, office, or home. For demonstration and literature, see your Wyeth representative.



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SAVES TIME, MONEY, WORKLOAD

1. Bogash, R.C., and Pisanelli, R.: Hosp. Management **80**:82 (Nov.-Dec.) 1955. 2. Hunter, J.A., et al.: Hosp. Management **81**:82 (March) 1956. 3. Hunter, J.A., et al.: Hosp. Management **81**:80 (Apr.) 1956.

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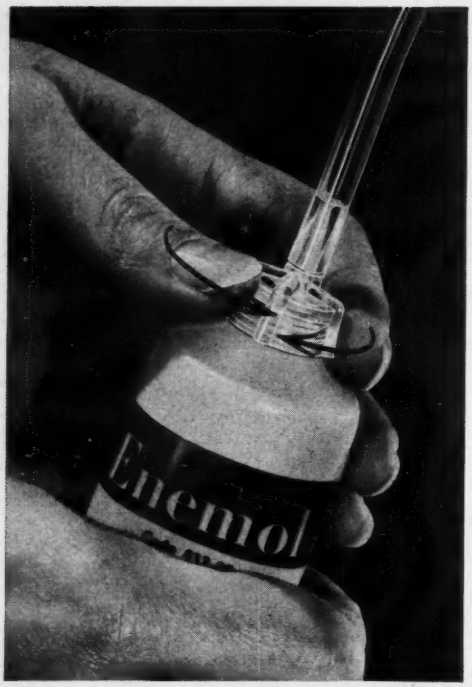
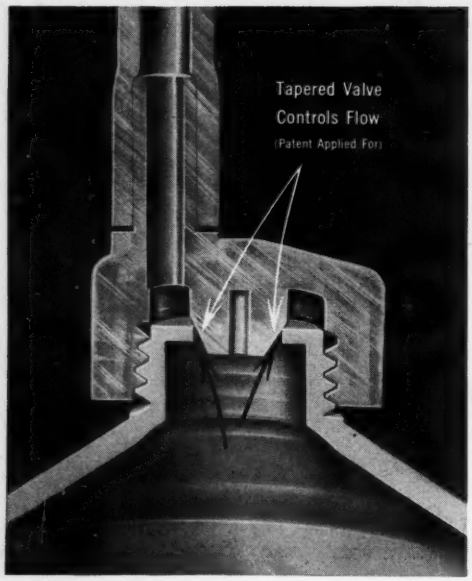




Turn-Valve Cap Gives New Enemol* Positive Flow Control

Just a turn of the valve cap on this Cutter disposable enema unit allows critical adjustment from closed to desired rate of flow. All awkwardness of control during insertion is eliminated . . . a turn for the best in enema administration. This Cutter *exclusive* valve design even permits the clearing of air from the rectal tube prior to insertion.

Clinical Tests Lead to Optimum Rectal Tube

These tests produced a 6 inch rectal tube sufficiently stiff for ease of insertion yet smooth and pliant to the patient. Possible damage to the mucosa is prevented by the soft round tip.

Control Numbers on Every Unit

Positive indication of safety and uniformity is maintained through rigid controls and tests of Enemol.

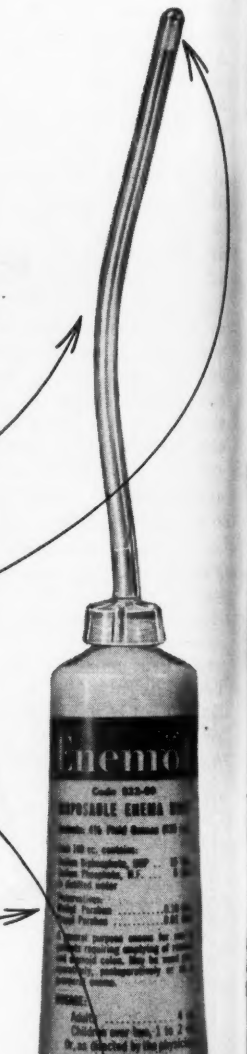
Enemol Formula

Clinical studies show that for routine enemas, the time-proved phosphate solutions are superior for both cleansing effects as well as cost of administering.[1]

Packed in easy-to-handle 24 to a case, 4½ oz. units.

1. Kehlmann, W. H., Time Study On New Enema Technic, Modern Hospital, May 1955.

*TM



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Enemol

CUTTER LABORATORIES
Berkeley, California

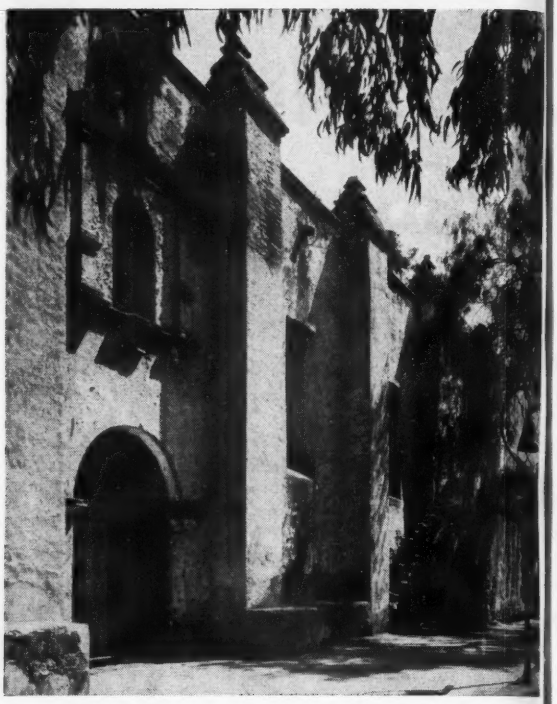
The OR

Local Planning Committee for Fourth Annual A.O.R.N. Conference

Members of the local planning committee for next year's A.O.R.N. Conference, met at the Statler Hotel in Los Angeles recently. Seated (l. to r.): Bethene Zalm, Hospital of the Good Samaritan, Los Angeles, program committee; Joan Coe, Hollywood Presbyterian Hospital, Los Angeles, entertainment; Viola Rodderick, Beverly Community Hospital, Montebello, co-chairman; Ethel I. West, Methodist Hospital of Southern California, Los Angeles, chairman; Mary Kreitz, Kaiser Foundation Hospital, Los Angeles, president, Los Angeles A.O.R.N.; J. M. de los Reyes, M.D., A.O.R.N. interprofessional coordinator; Helen Jensen, John Wesley County Hospital, Los Angeles, entertainment committee.

Standing (l. to r.): Jeanne Najar, Los Angeles General Hospital, registration committee; Vivian Warren, White Memorial Hospital, Los Angeles, program committee; Pierrette Legare, UCLA Medical Center, Westwood, program committee; Madonna McGlone, Queen of the Angels Hospital, Los Angeles, program committee; Jerry Peers, UCLA Medical Center, Westwood, scientific committee; Cecelia Lim, Kaiser Foundation Hospital, Los Angeles, hospitality committee; Levis Duke, Surgical Office Nurse, Los Angeles, program committee.

The committees are planning an excellent program for the conference. For further details, see the following pages.

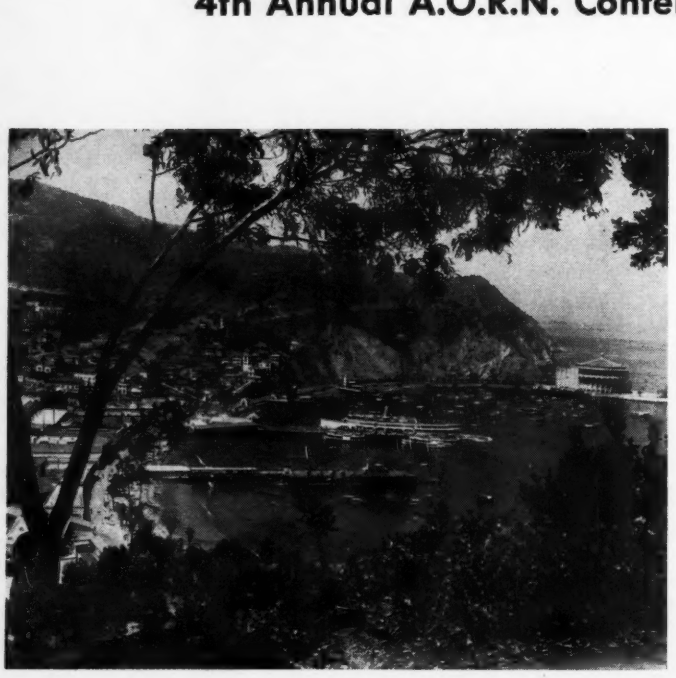


One of the picturesque Spanish missions in the area—at San Gabriel.

Plan now for

LOS ANGELES in '57

4th Annual A.O.R.N. Conference



Avalon Bay and South Catalina Island—one of the popular pleasure spots.

NOTICE TO A.O.R.N. GROUPS

The mailing list of A.O.R.N. groups is not accurate or complete. Please send me the correct address and also the number of members in your group as promptly as possible.

Edith Dee Hall, R.N., Chairman
National Conference Planning Committee
Association of Operating Room Nurses
305 W. 18th Street
New York 11, N.Y.

Above: Famous Wilshire Blvd. The Statler, headquarters hotel for the conference, is on this street.

Below: Nearby Disneyland appeals to adults as well as children. In 1890-era town square, horse-drawn vehicles leave for tour of area. In left background is Disneyland's City Hall, in the center the fire department, and on the right the Emporium, an old-time general store.

For the star-gazers — the Griffith Observatory.

PROGRAM HIGHLIGHTS

- The Recovery Room
- Cardiac Arrest
- Problem-Solving Technics (leadership, supervision, management aids)
- What O.R. Nurses Should Know About Malpractice
- Eye Bank and Eye Surgery
- Methods of Sterilization

Are you facing heavy schedules in the operating room? Why not make plans now for a winter vacation in 1957? A sunny California welcome awaits you at the fourth annual A.O.R.N. Conference in Los Angeles—February 18-20.

No other meeting has such an extensive program planned entirely by and for operating room nurses. You will have an opportunity to hear leading speakers in your field talk about subjects of vital interest to you.

Exhibits invited because they are related to your specialty will give you a chance to see equipment demonstrated and get on-the-spot answers to your maintenance and operation problems.

Operating room nurses on the planning committees are working hard toward a successful conference. If you have ever attended an A.O.R.N. Conference, no "sales talk" is necessary. If you have never attended one, a treat is in store for you. You will find others with problems similar to yours, and you will be impressed with the open, well-informed discussions which result in solutions to these problems.

You will be more valuable to your hospital because of the increased knowledge of your specialty which you will take home with you.

Why not plan to take your vacation at that time, so that before or after the meeting you can enjoy the delightful climate and see the many places of interest around Los Angeles?

See how little it costs to get to sunny California, where your own convention will throw "light" on a lot of problems.

Edith Dee Hall, R.N., Chairman
National Conference Planning Committee

AIRLINE RATES

Lowest round-trip air rates from some of the leading cities to Los Angeles and return (tax included):

Albuquerque, N.M.	$108.68	Memphis, Tenn.	$172.70
Atlanta, Ga.	193.38	Miami, Fla.	252.34
Baltimore, Md.	215.60	Minneapolis-St. Paul, Minn.	180.40
Birmingham, Ala.	181.50	New Orleans, La.	177.98
Butte, Mont.	127.16	Omaha, Nebr.	142.20
Chicago, Ill.	167.20	Phoenix, Ariz.	39.60
Cincinnati, Ohio	191.40	Pittsburgh, Pa.	211.20
Cleveland, Ohio	198.00	Portland, Ore.	87.23
Dallas-Ft. Worth, Tex.	125.40	Reno, Nev.	56.98
Denver, Colo.	94.60	Roanoke, Va.	228.38
Detroit, Mich.	189.20	Rochester, N. Y.	218.35
El Paso, Tex.	78.10	St. Louis, Mo.	160.60
Helena, Mont.	134.64	Salt Lake City, Utah	66.55
Houston, Tex.	149.16	San Francisco	29.70
Kansas City, Mo.	149.60	Seattle, Wash.	100.10
Louisville, Ky.	189.86		

Excursion flights at even lower rates are available Monday through Thursday from the following cities:
Boston $196.68 (tourist rate, $233.20)
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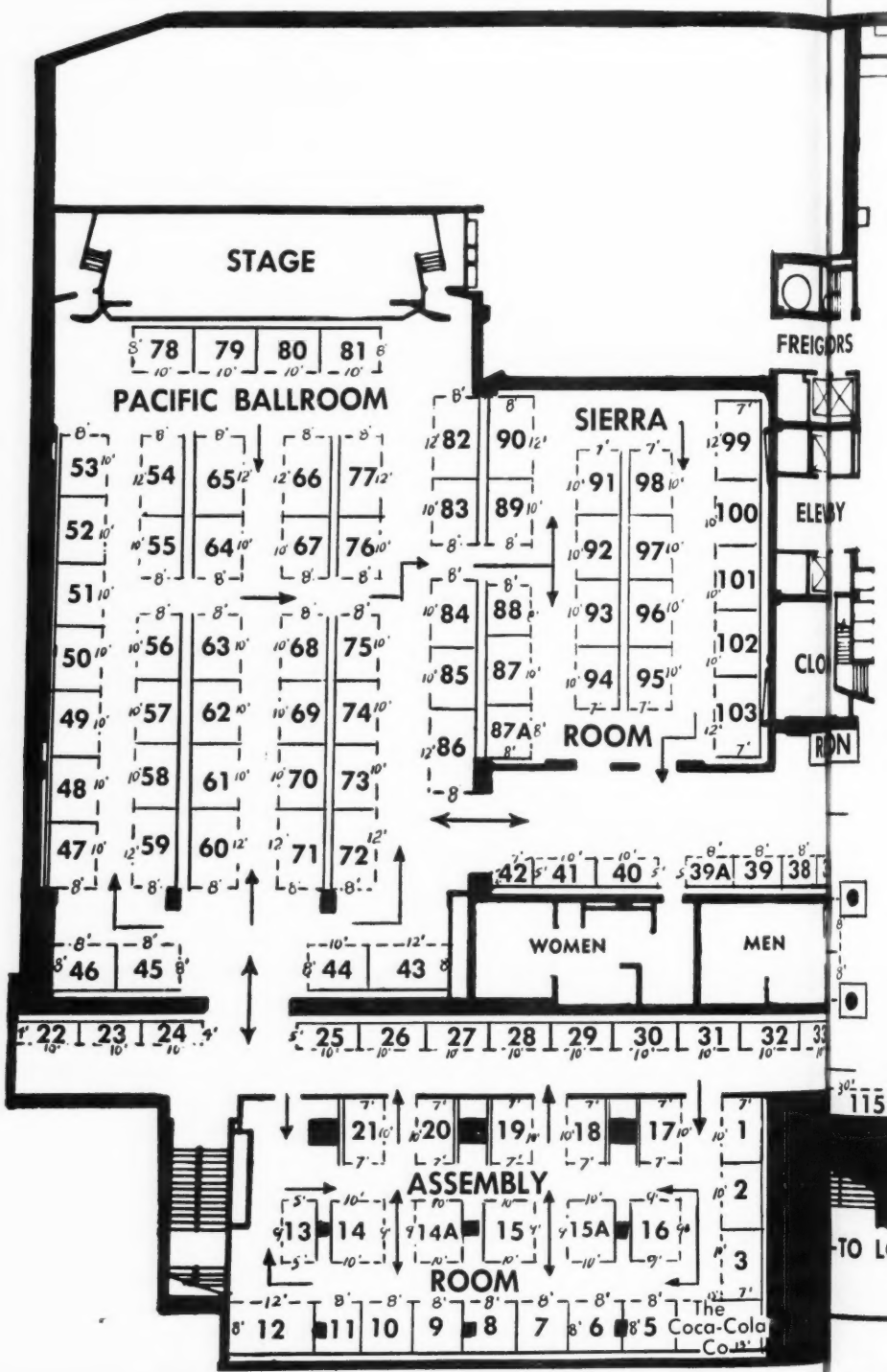
4th ANNUAL CONFERENCE
ASSOCIATION OF OPERATING ROOM NURSES
HOTEL STATLER, LOS ANGELES, CALIF.
FEBRUARY 18, 19, 20, 1957



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American Cystoscope Makers, Inc.
American Safety Razor Corp.
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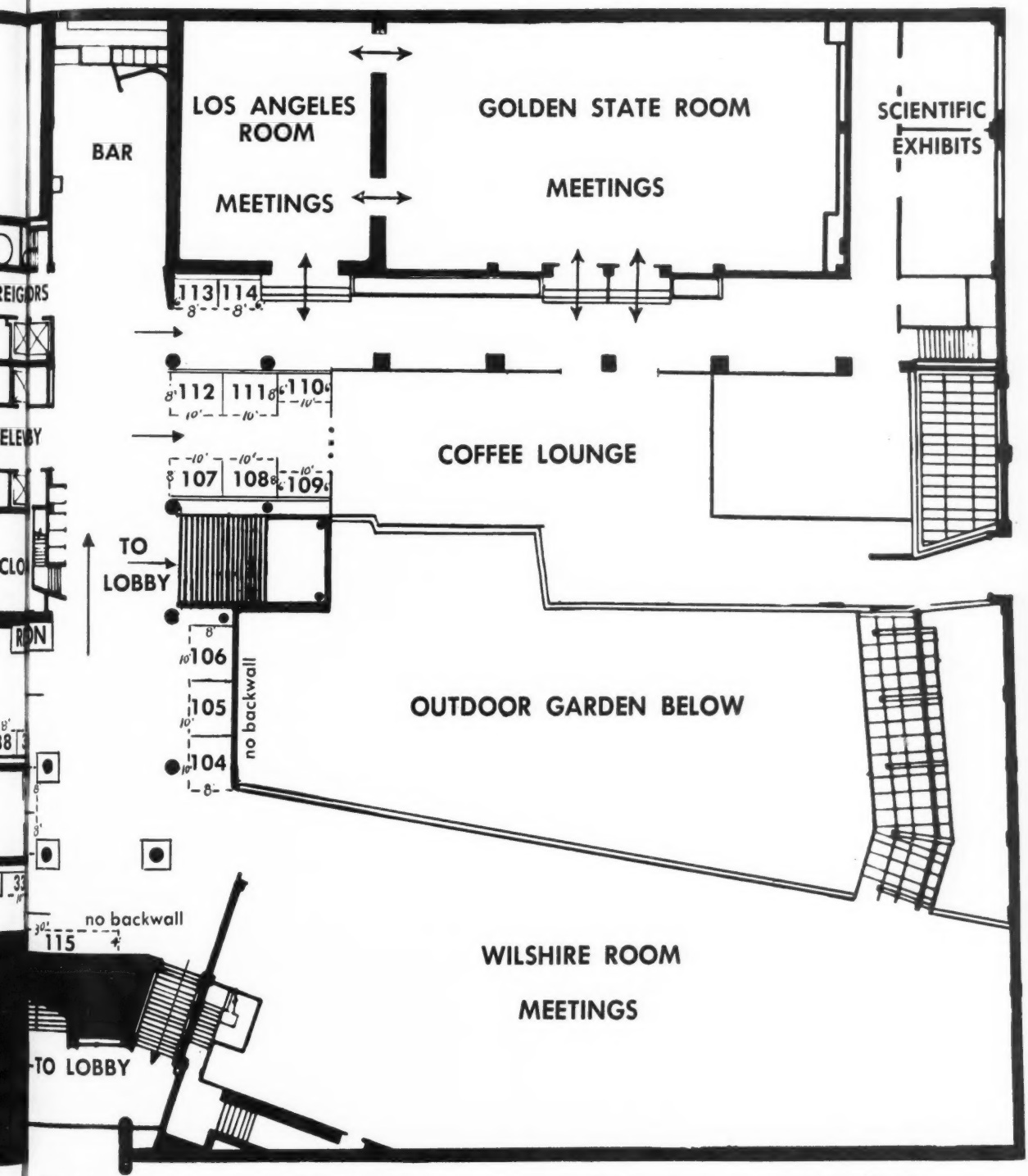

Duke Laboratories
E & J Mfg. Co.
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Nursing Opportunities in Plastic and Reconstructive Surgery

By Richard C. Webster, M.D., Richard J. Coffey, M.D., Virginia Rainville, R.N., Muriel Dow, R.N., and James A. Russell, APSA

Part I — Planning

In 1945, we began taking reconstructive surgical services where they were needed in eastern Massachusetts.

In planning a service organization, it is helpful to select a goal. This was our first step. The goal was, and is, to provide the finest reconstructive surgical services for all who need them at the lowest possible cost to the patient.

We had to know what the needs were. A knowledge of plastic and reconstructive surgery already told us what kinds of patient abnormalities we could eliminate or help. But how many patients had these kinds of abnormalities? Where were the patients with these problems? Were any people who needed these services not getting them? Would all patients who required plastic surgery come to one or two centers in a big city?

In analyzing the needs, we came to these conclusions:

1. Plenty of patients needing the services we could provide were not getting them.
2. Many were in community hospitals.
3. An appreciable number would not or could not come to city centers.

One further question had to be answered. Could plastic surgical patients get as good care in the community hospitals as in the centers? We carefully observed patients with comparable problems in both kinds of hospitals. In general, the care was equally good in both types of hospitals for most plastic surgical patients. For some, the smaller community hospitals had the advantage; for certain others, the bigger centers were better.

As soon as we knew that fine services could be provided in almost any hospital for plastic surgical patients, we knew that we had to build an organization to take the services where they were needed. Because long distances compound overhead expense problems greatly, we tentatively selected eastern Massachusetts as our service area. It still is today.

We firmly believe that the key figure in medicine is the family physician. Whenever one of our plastic surgical patients has a family physician who goes to the hospital in which we have the patient, we try to have his family physician carry out any parts of the over-all care he is capable of providing. Teamwork cuts down the total costs greatly to the patient.

What the family, local, or referring physician cannot or does not want to do, we must do. It is here that our nurses have made one of their greatest contributions. With enough special training in the needs of the plastic surgical patients, they have been able to share with the plastic surgeons almost all of the pre- and post-operative dressings and treatment maneuvers required in our field. Were it not for our nurses, we would have to turn many patients away and charge much more for the same services.

We have spent much time in thinking about delegation. We believe that the months of special training which our nurses have, qualify them to do many things which a few years ago only the doctors did. They do not operate, of course; but in most of the other aspects of patient care they do the job as well as the surgeons.

(Continued on page 112)

* From The Webster Clinic for Plastic and Reconstructive Surgery, Brookline, Mass.

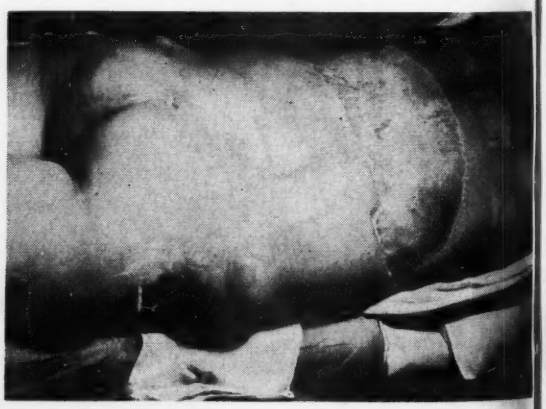
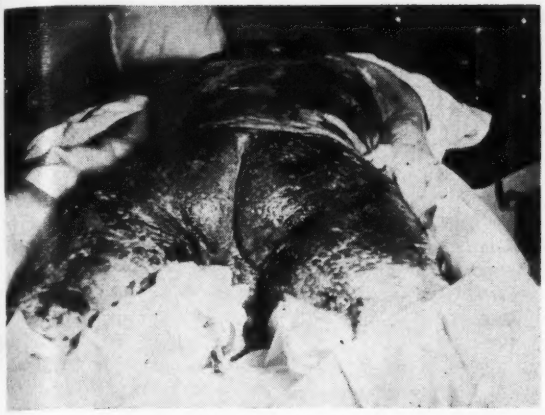


Figure I. Above, left: Left side before surgery. Huge sacral and large trochanteric ulcers. At right: Ulcers closed by moving flap downward and by skin-grafting. Flap donor site covered with split-thickness skin grafts. Donor sites for these show near shoulders. Patient now ready for rehabilitation.



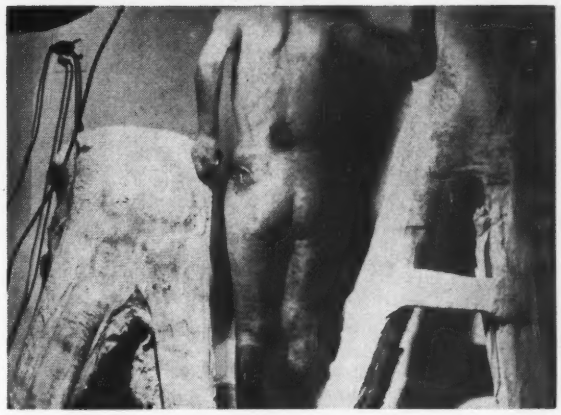


Figure II. Above: Photograph on first visit to patient after constructing weight-bearing shell. Padded contours fitted to patient distribute pressure away from bony prominences, prevent bed sores.

Above, right: Going home 41 days later. He is shown holding anterior and posterior burn casts. Anterior and posterior skin-grafting procedures were used. Wounds are completely healed.

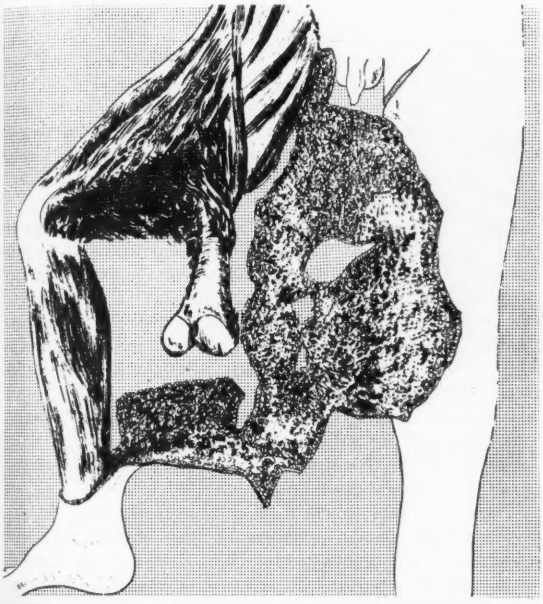


Figure III. Severe compound dislocation. Lower leg hangs by shreds of muscle, tendon, ligaments and, fortunately, enough blood vessels and nerves. Skin and fat of entire leg are narrowly attached only at angle and groin. Below: Reconstruction of knee has been successfully accomplished; now leg must be skin grafted. Note how posterior plaster shell cradles leg. Anterior part is to be grafted first, thicker grafts to be used around and on knee to minimize shrinking and withstand expected wear and tear. Above, right: Full flexion and extension are possible. There are no long vertical, straight-line scars to contract and limit motion. Full-thickness skin grafts applied in the knee area "took" 100 percent, despite being left in open air with pressure dressings.

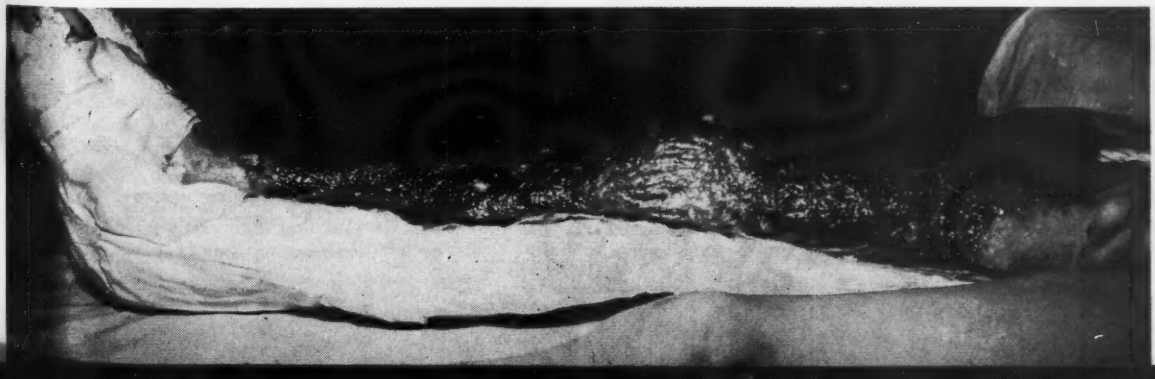
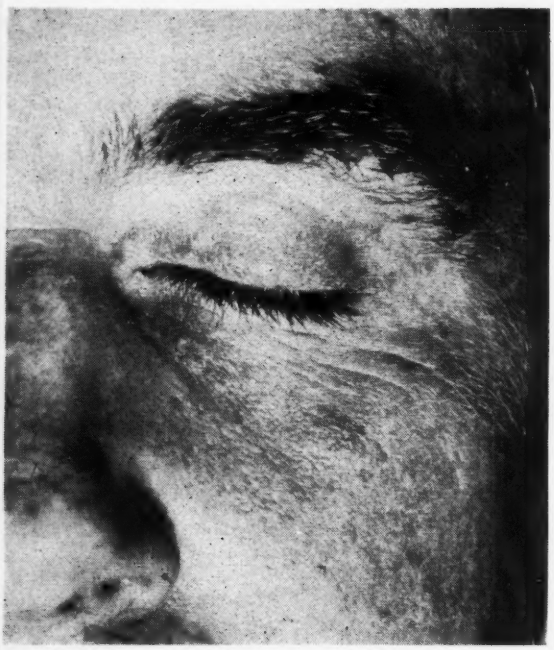


Figure IV. Cancer of upper eyelid. This lesion was excised with a one cm. margin to effect cure.



Above: Cured after wide excision and plastic reconstruction. Can you find any scars? Actually, they are partly hidden in normal folds.

Part II — The Role of the Nurse in the Distribution of Medical Care

There are six major reasons for doing plastic surgery. We have selected patients illustrating each reason. These will show how the principles of delegation work when applied to the nurses in the distribution of reconstructive surgical care.

1. To SAVE LIFE

The patient shown in Figure I, a carpenter, fell 12 feet, fractured his spine, and cut the spinal cord. He was dying of infection and from loss of proteins and other vital substances from multiple decubitus ulcers of his sacral and trochanteric regions and of the calves, heels, and ankles. Before attempting surgical closure of the ulcers, we had to get him to eat and to want to live.

Nurses' part:

Preop: Many visits to hospital (over 40 miles away) to do dressings and to help build up morale and nutrition.

Operation: Second assistant.

Postop: Numerous visits. Suture removal, recipient and donor site dressings, drain removal.

2. To STOP PAIN

The young man shown in Figure II had extensive third degree burns. His agony was minimized by construction and use of weight-bearing plaster body shells and early skin grafting. Excellent teamwork got this patient home 41 days after the first photograph was taken. Two massive skin-grafting procedures were done. Forty-three to 45 percent of body surface showed third degree burns.

Nurses' part:

Preop: Dressings, debridements, cooperation with dietitian in nutritional regimen, instruction to hospital nurses in care of major granulating wound.

Operations: Scrub nurse.

Postop: Dressings to recipient and donor sites, rapid mobilization routine, nutrition.

3. To REPAIR RAVAGES OF MACHINE AGE

The trousers of the boy shown in Figure III were caught in the drive shaft of a lumber truck. The drawing shows the extent of his wound. The lower end of the femur was torn out of the knee joint, and the skin and fat of the leg were twisted and ripped off as demonstrated. The conviction that amputation was the last thing to do, not the first, saved this youngster's leg. The knee joint was reconstructed and the leg covered with split and full-thickness skin grafts. Timmy now enjoys full activity. The fact is, he fractured his arm one year later playing basketball!

Nurses' part:

Preop: Dressings, debridements, morale-building, nutrition, construction of plaster shell, preparation of granulations for grafting.

Operation: Second assistant.

Postop: Dressings to donor and recipient sites, suture removal, morale-building, nutrition.

4. To REMOVE LESIONS AND REPLACE THE MISSING PARTS

In cancer surgery, our usual goal has three parts:

(1) Curing the patient

(2) Restoring function

(3) Restoring appearance.

They are listed in their order of importance.

The patient shown in Figure IV was a young man with a cancer of the upper eyelid. To be as sure as possible of curing him, we had to remove normal tissue around his cancer along with the tumor itself. Therefore, the medial half of the outer parts of the eyelid down to the eyelash border and part of his eyebrow were removed. The plastic repair was accomplished with a rotation flap from his nose, an advancement flap from the rest of the eyelid, a z-plasty, and an eyebrow reconstruction. He now has normal appearance and function and has had no recurrence of his tumor in over five years.

Nurses' part:

Preop: Nothing.

Operation: First assistant.

Postop: Removal of dressings and sutures at office.

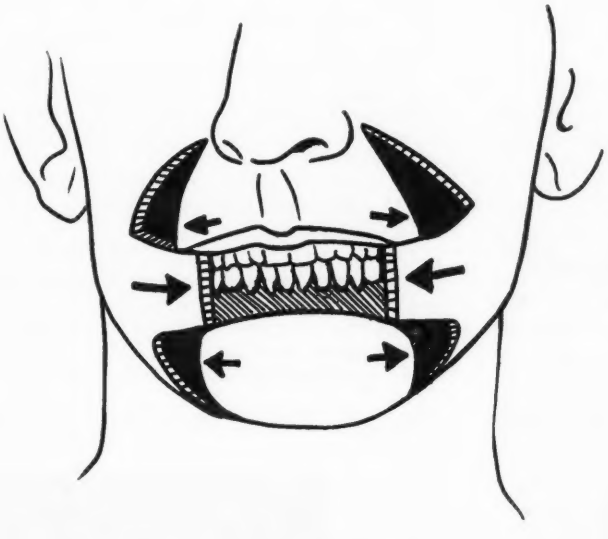
The patient in Figure V was an older man with a grade two squamous cell carcinoma of the lower lip. It extended to within 11 mm. of the commissure on the right side and even less than that on the left. His entire lower lip was excised, and a new lip was made from his cheeks in the same operation.

He has no evidence of recurrence over five years later and can eat, drink, control his saliva, and speak

(Continued on page 114)

Figure V. Ulcerated crusted carcinoma of lower lip. Entire lower lip was removed to cure patient.

Above, right: New lower lip of adequate size.



Left: In total excision of lower lip shown above, two cheek flaps of skin, fat, muscle and mucous membrane were used in repairing it. Arrows indicated direction of advancement for closure of defect. Note how most lines of closure (later scar lines) will fall in natural folds of face.

Figure VI. Infant with double cleft lip and palate. Picture shows roof of nose through wide clefts in palate. Note how far forward the tab of tissue, which should be middle of the upper lip, is displaced. Above, right: After first operation. Clefts in lip closed. Note beginnings of the Cupid's Bow.

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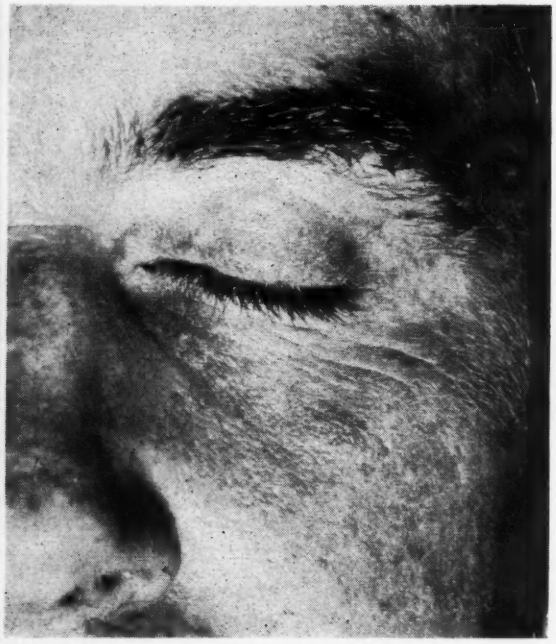

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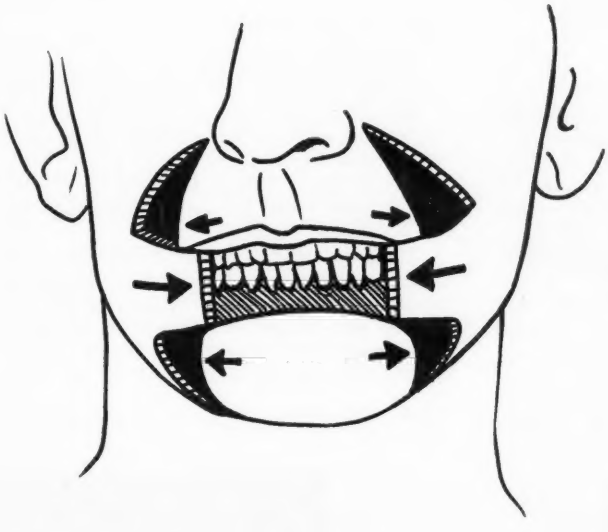

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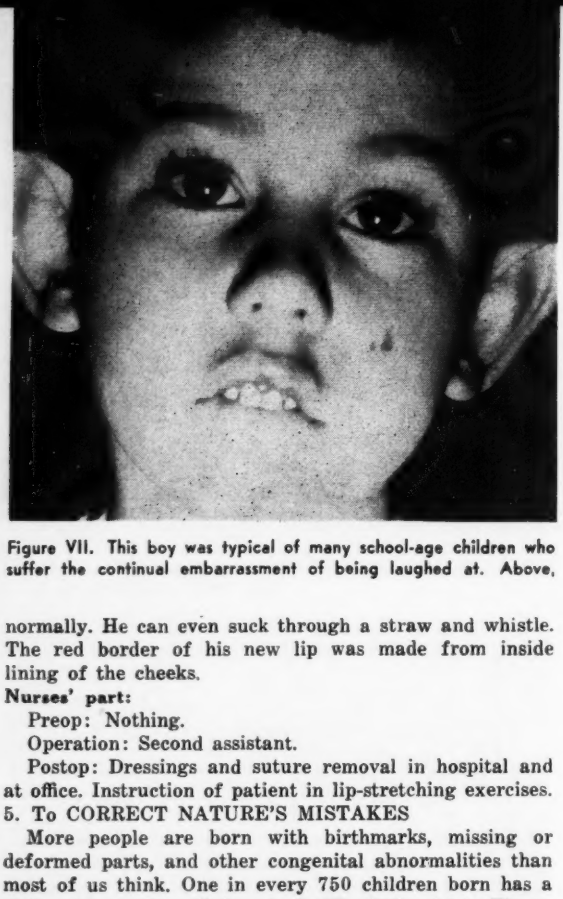


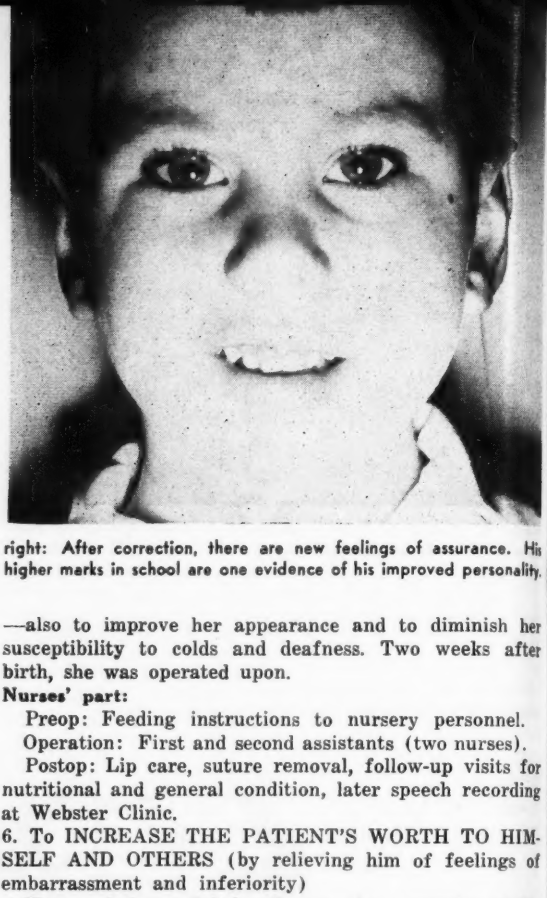


Figure VII. This boy was typical of many school-age children who suffer the continual embarrassment of being laughed at. Above, right: After correction, there are new feelings of assurance. His higher marks in school are one evidence of his improved personality.

normally. He can even suck through a straw and whistle. The red border of his new lip was made from inside lining of the cheeks.

Nurses' part:

Preop: Nothing.

Operation: Second assistant.

Postop: Dressings and suture removal in hospital and at office. Instruction of patient in lip-stretching exercises.

5. To CORRECT NATURE'S MISTAKES

More people are born with birthmarks, missing or deformed parts, and other congenital abnormalities than most of us think. One in every 750 children born has a cleft palate or "harelip" or both. The little girl in Figure VI, a nurse's daughter, had a "double" cleft lip and palate. She had a so-called "wolf snout" deformity. The tissues that should have made up parts of her nose, the middle of her upper lip, and part of her gum were rammed far out and forward.

Plastic surgery had to be done to allow her to suck, chew, swallow, breathe, and eventually speak normally —also to improve her appearance and to diminish her susceptibility to colds and deafness. Two weeks after birth, she was operated upon.

Nurses' part:

Preop: Feeding instructions to nursery personnel.

Operation: First and second assistants (two nurses).

Postop: Lip care, suture removal, follow-up visits for nutritional and general condition, later speech recording at Webster Clinic.

6. To INCREASE THE PATIENT'S WORTH TO HIMSELF AND OTHERS (by relieving him of feelings of embarrassment and inferiority)

The psychology of deformity may be a complex study, but it is easy enough for anyone to understand the acute embarrassment and the withdrawn personality of the person who is constantly stared at or laughted at. In a famous study on deformity as a factor in crime,* it was found that plastic surgery helped all but 2.6 percent

* Pick, J. F., *Surgery of Repair, Principles, Problems, Procedures*. Vol. I, pp. 430-31. Philadelphia: J. B. Lippincott Co., 1949.

Figure VIII. Left: A cosmetic problem with clear emotional, social and economic complications. At right: A new nose — a new life. This girl can face others with new confidence.

deformed criminals "go straight"—compared with the 20 percent to 78 percent average recommitment rates. No one really can evaluate the amount of emotional agony of the person who thinks himself different from others in an unpleasant or laughable way.

The first example (see Figure VII) was a little boy with bilateral protruding ears, a cruel deformity because it is thought "funny" by everyone but the child and his parents. "Dumbo," "Jughead," "Dog-Ears," and "Loving Cup" are but a few of the brands these unfortunates carry from the beginning of school days onward. Prevention of irreparable psychological scars was the goal of plastic surgery.

Nurses' part:

Preop: Local preparation.

Operation: First assistant; application of molded splinting and pressure dressing.

Postop: Dressing at office.

A large nose can be measured in inches, but the indication for correction lies within the mind of the patient. A young woman, such as the one in Figure VIII, is painfully aware of the appearance of her nose. If she is hindered socially or is restricted in job opportunities, then she needs help.

Nurses' part:

Preop: Local preparation.

Operation: First assistant, application of splint.

Postop: Removal of packs and splint.

Obviously, the nurses have been quite active in the care of these patients. The surgeon must judge what methods should be used for each individual patient and do the operations. With proper training the nurse can do most of the dressings and can make most of the hospital visits. We feel that the nurse is the ideal answer to many of the economic problems of patient care.

Part III — Nurses' Role in Teaching and Research

Because we wish to get the finest results for patients and to continue to improve the quality of our services, we must teach constantly. The surgeon must continually impart information to and encourage new skills in those who work with him.

This information and skill cannot be allowed to stagnate. It has to reach those directly concerned with the care of the patient (See Figure IX).

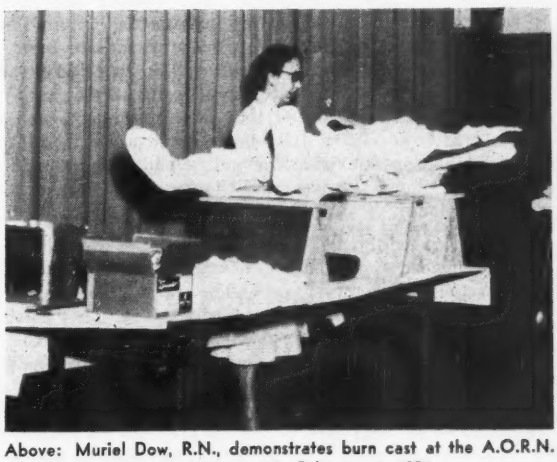
It is essential that this skill be taught because the patient must be prepared for surgery in the morning by having just such dressings done every four hours, starting the night before surgery. With this method, pale, watery, dirty, edematous granulations can be transformed into pink, firm, clean, flat areas producing a fertile field for the "take" of skin grafts. Under these practical, realistic conditions we find that our nurses teach effectively and that the ward nurse proves an apt student.

In the operating rooms, nurses are expected to inform others about the special technical details of plastic surgery—the dozens of little things that make the big differences in a plastic procedure. For example, the plastic surgeon, and the patient's tissues, can tell the difference between a new blade soaked three minutes and a blade soaked several days. Soaking too long dulls the edge he so often needs to get the finest results. Since the three-minute soak is not routine in any hospital, our nurses have to teach personnel this and other special needs.

Proper handling of small, delicate instruments, fine sutures, special splinting devices, and certain dressing materials, instrument set-ups, draping and lighting requirements—these and many other details must constantly be taught to hospital and visiting members of the profession.

Figure IX. Students and graduates are shown how to prepare this burned leg for skin-grafting the next day.

Above: Webster Clinic nurse teaches the proper set-up for a nasal plastic operation.



Above: Muriel Dow, R.N., demonstrates burn cast at the A.O.R.N. Conference in Boston, January 30—February 1, 1956.

Over 150 hours of formal lectures are given each year by Webster Clinic personnel. Our nurses help in this educational program in two main ways, by lecturing and by helping prepare the presentations. Over 10 hours of work go into the preparation of a one-hour lecture. Extensive use is made of audiovisual teaching aids, and time and skill are required for their preparation. All Webster Clinic personnel are engaged in this work "behind the scenes." We have found that our nurses can put many points over to other nurses, in formal lectures, better than our surgeons can.

(Continued on next page)

Movies, exhibits, and papers are three other teaching activities which engage the attention of our entire organization. Every one of these activities not only benefits our patients and nurses but also raises the level of care for other patients and of education of other nurses.

Almost everyone agrees that research is good and that it should be done, but all too many think George should do it. We feel that it is the crux of better care for the future, and we recognize that to teach well and intelligently we must first carry on research into the experience of others and into our own experience. Therefore, essentially everything we do is recorded. The data thus accumulated are indexed on IBM cards and analyzed in the research process, and the nurses are engaged in every step along the way.

Later, when information is needed, it can be found in a few minutes instead of the hours or days that might be required without this system. One very important advantage is that anyone in the office can find the information for the doctors without any briefing or supervision.

Many nurses have wondered why our nurses learn about and help with photography. Color photographs of our patients are in many respects the most important parts of the plastic surgical record. Words cannot *show* what a patient looked like before correction of his deformity.

Over 50,000 feet of 16 mm. color movies and over 15,000 35 mm. color slides have been taken of our patients. Our nurses have assisted in making these pictorial records, and also have been involved in the teaching and research done from the movies and slides. They are constantly engaged in research in the nursing phases of reconstructive surgery. Numerous improvements in nursing care routines and in dressing technics can be attributed to them.

Simplification of our instrument kits is a good example. We cover a large area and operate in over 55 hospitals. We must do surgery in many parts of the body. At one time we carried a large number of special instruments. Since every extra instrument hinders kit portability, increases chances of loss, and adds to instrument handling time, our nurses carried out a critical and exhaustive instrument investigation, using work simplification methods. They found that 634 instruments could be reduced to less than 100 which would allow us to do all procedures in this field. The weight and bulk reduction saves professional tempers, and the time reduction saves patients' money.

Part IV — Predictions

We believe that the achievement of a worthwhile goal in medicine requires teamwork. The nurses in our clinic are an integral part of our professional life. They allow the doctors to accept many more patients for care than they could take on without competent professional help. We believe that the trend of increasing delegation is a healthy one and that it is the only way in which high standards of medical care in this country can be provided to all those who need care, at the lowest possible cost.

In view of this realistic need, nurses can only move upward, learning greater and greater skills and participating more and more closely with the doctor in many phases of patient care. As the skills and responsibilities of the nurses soar higher and higher, the nurses in turn will have to delegate responsibilities and authority to nurse's aides, operating room technicians, and other helpers of many kinds. These people in turn must be trained to fill the gap by taking over the more mechanical duties of nursing care.

We disagree with the archaic concept that only the surgeon can touch the dressings, that only the surgeon can tell which stitches should come out. In plastic surgery today, there are far too few qualified men to care for all those who have the need for plastic surgery. We have to have help, and our nurses give it to us.

This has not been an easy concept to put across in conservative old New England. Patients have seen the common sense in it and have accepted it readily in almost all cases; but many nurses, doctors, and hospital administrators have had to be shown. The sincerity, capability, and diligence of our nurses have accomplished wonders in showing the doubters what can be done by a service group working together.

What of the future?

In 10 years there will be over a 15 percent increase in population. There will be almost a 30 percent increase in the number of old people and almost a 40 percent increase in the number of school-age children. Forty percent more cars will be clogging the highways.

In 10 years the American worker will have a 37-hour work week, and 150 more leisure hours per year than he has now. There will be almost a 30 percent increase in disposable income—the money left over after taxes. There will be a 50 percent increase in the number of people going to college.

With more people, more money, more leisure time, and more education all added to the enormous growth of prepayment health insurance plans, the people will be needing and seeking earlier and ever more medical or health services.

The demand, the market is there already; it will be even greater in the future. How do we supply it? Doctors and nurses are not increasing in numbers fast enough to keep up with the demand. To become a qualified plastic surgeon at least 15 years' training beyond high school is required. Today there are only about 215 qualified plastic surgeons practicing in this entire country. Just a few can be trained at a time. Our group cannot see any glut of nurses on the market ahead.

The supply is short today and will be shorter tomorrow. Our professional responsibilities are and will be enormous. Our challenge is to find new ways of training, more and better ways of delegating, and more intelligent and progressive methods of upgrading skills, responsibilities, and the authority to go with the responsibilities. The American public cannot afford the luxury of having highly and expensively trained people doing things that less skilled personnel can do under supervision.

Think what the increase in industrial development means to nurses. Promotion of safety programs, emergency first aid, continuous plant coverage, day-by-day maintenance of health services, in many places are already here. Will doctors be able to provide all the diagnostic, preventive, and therapeutic services the labor unions and management want for the workers of tomorrow? Of course not. Nurses will have to help, and they will have to be paid commensurately with their skills and responsibilities.

The ever-rising trend toward suburban living means more time and longer distances involved in physicians' house calls. We see a dramatic future increase in the number of nurses making house calls to carry out home care under the direction of physicians. Anyone who has had to make bedside decisions in the home knows the heavy weight of responsibility which lies on the shoulders of the person who has to make the decision. The need will be for super nurses—not humdrum, irresponsible ones.

There can be only one road ahead for nurses. It goes upward—into services formerly thought of as purely doctor-provided. When surgeons do what they alone can do, and, by planning, allow nurses to do what they are capable of doing, everyone benefits—the patients, the nurses, the physicians, and the public.

The O.R. Problem Clinic

by EDITH DEE HALL, R.N.

Better O. R. Student Experience Vital for Future Patient Care

• One problem confronting operating room supervisors today is that of giving adequate graduate nurse supervision to the nonprofessional or surgical technical aide. Is the problem widespread, will it increase, and what is the solution? This is a weighted question, and the answer cannot be reached without a joint effort on the part of professional nurses.

Surgical technical aides have filled an important need. They have learned to perform tasks that do not require the skill of a professional nurse — but let us not delude ourselves into thinking that the aide has been the answer, and that everything is under control. The load has been lightened, but the professional nurse has been forced to shoulder more responsibility for the performance of others.

According to planned teaching programs, the surgical technical aide is permitted to perform certain duties, such as scrubbing for operations, only under the supervision of a professional nurse. This creates a problem. From my own observation and knowledge of existing conditions, it would seem that either we do not agree on the definition of supervision or there is a new kind that penetrates walls. Do we mean that a professional nurse is to give constant supervision to the scrubbed aide, or is she to look on at intervals? How is it possible for one person to supervise properly in three or four rooms at the same time?

Occasionally I hear an operating room supervisor boasting that she has nonprofessional workers who are superior to certain professional nurses. Is it fair to the patient to have the service of one who is superior to the least competent rather than comparable to the best? Is there any doubt that in the operating room we need only those who are adequately prepared to function with safety and effectiveness at all times? With a gradual and steady decrease in the number of experienced operating room nurses, no time should be lost in improving conditions.

We are told that anyone can be taught to scrub for an operation. By the same token I believe that I could be taught to do an appendectomy, but does that make it right?

We need to go back to our student and insist that she have better preparation, that something be done to interest her in this specialty. What happens when we shorten or eliminate operating room service from student experience? How will this affect conditions in the future? What is being done to provide opportunities for advancement to the young graduate who wishes to specialize in operating room work? A staggering amount of time, energy, and money has gone into programs for the nonprofessional. Is it unreasonable to ask that an equal amount be used in the development of the professional nurse?

Professional organizations are quick to tell us they can meet the needs of the operating room nurse. Have we actually brought them face to face with the need, with conditions which multiply constantly? I still maintain that, to be fully informed, you must "see it yourself." This knowledge cannot be gained from reports and relayed complaints. What about crowded schedules, long, tense hours of overtime, and night call — circumstances which become so routine that the faithful accept them and others shy away and refuse to get involved?

So much stress is placed on total patient care that I find myself asking, is there any other kind? It takes parts to make the whole, and operating room service is one part which is vital to the survival of the surgical patient. Our surgeons are sympathetic, and some are even alarmed by our talk and complaints. I believe that many only need an intelligent

(Continued on page 134)

Hospital Convention Coming Up

The big American Hospital Association meeting is coming up in Chicago in September.

As usual, Diack Controls and Inform Controls will be represented as one of the exhibits.

Other companies will be there to show their equipment, but few firms can equal the 47-year record of Diack Controls.

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OR QUESTION BOX

BY CARL W. WALTER, M.D.

Assisted by Dorothy W. Errera, R.N.

Q. I read of your technic in autoclaving with dry heat baskets of unwrapped syringes tipped with plastic tips to seal and keep sterile. I have carefully followed the technic because I think it a marvelously efficient and economic procedure. However, I repeatedly get a blow-out of the plunger from the syringe, with the plastic tip intact.

Thinking that it might be due to sudden opening of the autoclave when still under pressure, I had the steam turned off, waited till the pressure was down, then carefully cracked and opened the autoclave. One syringe was intact, the other completely apart. Obviously I am overlooking some important factor. Could you suggest something? I would greatly appreciate any help, as I think very highly of your procedure and would like very much to institute the technic here.

A. There are two possible reasons for the trouble you outline:

1. You are not assembling your syringes completely DRY.

2. You are sterilizing the assembled syringes in steam rather than *dry* heat. Your comment, "waited till the pressure was down," leads us to believe the latter is true. This technic is only successful if dry heat is used as the sterilizing medium. When an ordinary dressing sterilizer is used, this means introducing steam into the jacket *only*. The chamber heats by radiation and becomes essentially a dry-heat oven. At 250° F., it takes four hours to destroy dry resistant spores in dry heat.

Q. You say it is unnecessary to reautoclave sterile supplies. Why go through the trouble of dating them, then?

A. Personnel using sterile supplies need some means of distinguishing the sterile from the unsterile. It is not enough to just use separate storage or separate shelves — arbitrarily deciding that one is for sterile supplies and another for unsterile supplies. There is too much chance of error in sorting supplies in this manner — changes of personnel, vagaries of human behavior, etc. If supplies are routinely marked as they come from the sterilizer and personnel conditioned to checking for that mark before using sterile supplies, the patient is assured a measure of safety. It makes no difference if that mark be a date, an initial, or the new pressure-sensitive tape which changes color when exposed to heat.

Q. One of our g.u. men says that in some places tap water is used for transurethral resections and sterilization is not important. This hospital does have its own well of artesian water, which, I have been told, does not contain lime as other water does. How do you feel about this?

A. Tap water should never be used for distending the bladder during transurethral resection, because the likelihood of infusing some of the material into the veins of the prostatic bed is too great. When this happens, intravascular hemolysis of red cells occurs. This can cause acute renal tubular degeneration. It is good practice to use an isotonic solution, such as 1.25% glycine, as described in *Journal of Urology* 59:1212;1948.

In addition, tap water contains electrolytes which interfere with the action of cutting currents of the endothermy.

Q. What is the proper technic for sterilizing radon seeds before implantation?

A. That is difficult to answer because the technic of applying radon seeds varies so much. Immersion in any of the formaldehyde-alcohol germicides for three hours is satisfactory. In most instances, the seeds are implanted into the tumor so that a track is left to the outside and spore formers are not too much of a problem. Remember too that the rays are ionizing and destroy bacteria.

Q. I would like your opinion of the sterile solution warmer. The circular received says that it is explosion-proof, approved by Underwriters' Laboratories for explosive atmospheres. However, there seems to be some discussion about its safety and practicability among our staff.

A. The sterile solution warmer is an effective way of providing solution at the proper temperature for use in the surgical wound. If it carries the seal of approval of the Underwriters' Laboratories, it is safe for use in anesthetizing areas. Ordinary electric or steam-heated warming cabinets are safe for use in sterilizing rooms adjacent to anesthetizing locations. The temperature should be maintained at 140°F.

Q. We recently purchased an instrument washer-sterilizer and have been using the detergent supplied us by the manufacturer. It left an oily film on the instruments. After some experimenting with other products, we found one that eliminated the film but left the instruments spotted as though corroding. We also found that small black pieces of material began falling out of the joints of the instruments. We felt that the washer was not doing a thorough job of washing and returned to hand washing of our instruments.

A. The problem of finding a detergent suitable for use in a washer-sterilizer is a matter which must be decided on a local basis, because the detergent must be suited to the local water supply in each instance. Usually a non-ionizing detergent suitable for use in mechanical dishwashers wll be found satisfactory.

I suggest you obtain samples from your local dishwasher appliance store and try them in the recommended concentrations in your washer-sterilizer.

Remember that the sterilizer should be filled with cold water at the beginning of the cycle, because hot water is quite likely to coagulate the protein and make the work for the detergent harder. The black specks which you describe are usually hard blood which has dried in the recesses of the instrument.

Hand washing surgical instruments is not a tenable solution, because it requires handling with the hazard of contracting homologous serum jaundice as well as spreading sepsis throughout the clean-up room. For this reason, surgical instruments should be washed and sterilized mechanically as a terminal treatment. They can then be sorted, inspected, dried and stored.

HOSPITAL *Topics Announces*

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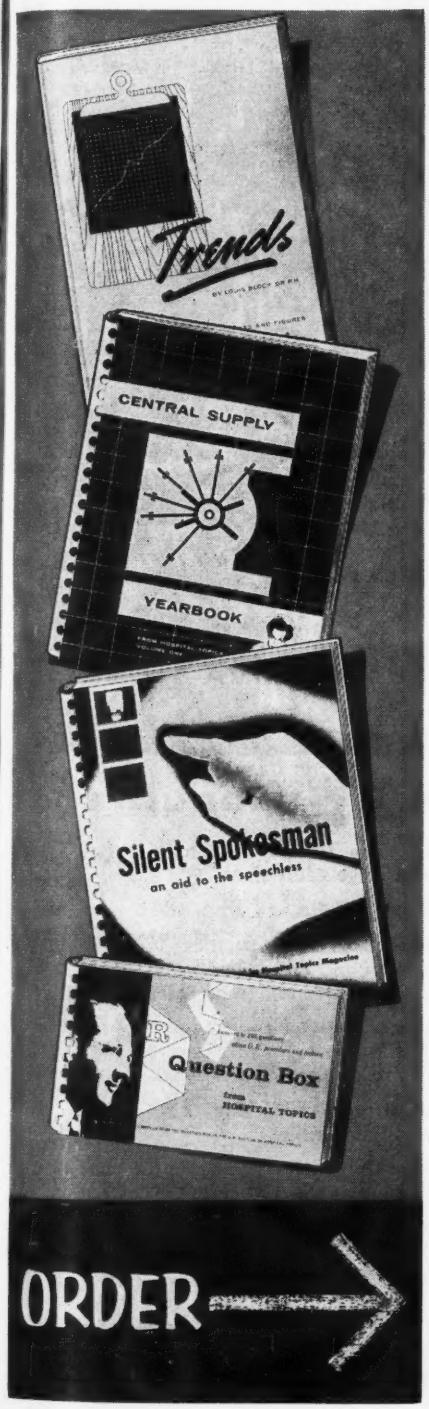
Available at the AHA Convention, September 17-20. Be sure to stop at HOSPITAL TOPICS Booths -- No. 952 and 149 -- and get your copies.



HOSPITAL TRENDS

By Louis Block, Dr. P.H. Chapters on controlling expenditures, budget, and cost analysis alone would be worth the price of this book. The book provides a clear, detailed analysis of changes in U. S. hospitals in the last 20 years — in size, average length of patient stay, bed occupancy, daily census, admissions, personnel, income and expenses, and other major areas. Another section — facts on the average hospital — will be a valuable tool to every trustee, administrator, department head, or student of hospital administration, because it correlates statistics on facilities, personnel, and finances for every major type of hospital. **$5.00**

CENTRAL SUPPLY YEARBOOK FROM HOSPITAL TOPICS

Volume I. HOSPITAL TOPICS in 1952 became the first hospital publication to recognize the importance of the central supply department by establishing a special section in the magazine for its personnel. Since then every issue has carried practical articles which help the CSR supervisor and her staff to do a better job. From those articles the editors have carefully selected the ones which appear in this yearbook — the first of a series. They deal with every major CSR problem, whether it's methods of sterilization, inservice training, or work simplification. Among the authors: Margaret K. Schafer, R.N., Frederick Markus and Jean Christie, R.N., Edna Prickett, R.N., Betsey Carroll, R.N., Velma Chandler, Ph.D. **$1.50**

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By Wayland W. Lessing. A time-saving "communication book" for every doctor, nurse, and attendant who has to deal with the patient handicapped by aphasia (loss of speech). Patients can make wants known by pointing to pictures of objects or to words and sentences which have been carefully selected to cover most common needs. Book eliminates frustrations of patient and nurse which result from patient's inability to make himself understood. **$1.50**

O.R. QUESTION BOX FROM HOSPITAL TOPICS

Carl W. Walter, M.D. Authoritative answers to 195 questions most frequently asked on operating room procedure and technic, compiled from the author's regular column in HOSPITAL TOPICS. Dr. Walter, associate clinical professor of surgery, Harvard Medical School, and a surgeon on the staff of Peter Bent Brigham Hospital, Boston, is a leading authority on operating room technic and author of *Aseptic Treatment of Wounds* (Macmillan). His institutes for operating room nurses throughout the country are always in demand. The questions in this book keep recurring as new personnel enter the operating room. The book will be a valuable reference aid to operating room supervisors and staff, directors of nurses, medical staff members, and administrators who want to keep informed on good operating room practices. **$1.00**

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For detailed descriptions of items listed above write: Davol Rubber Co., Dept. HT-6-9, Providence 2, R. I. **Patent pending*

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PRESCRIPTION PAD *(Continued)*

Cream for Skin Disorders

Tashan Cream, a multivitamin cream for relief of irritation, pain and itching in skin disorders, has just been released by Hoffman-La Roche Inc.

It is recommended by the manufacturer for relief in sunburn, irritated skin, diaper rash, prickly heat, itching, chapped hands and face, poison ivy, minor burns, and other skin irritations.

Each gram contains in a vanishing cream-type base: vitamin A, 10,000 U.S.P. units; d-panthenol, 50 mg.; vitamin D_2 1,000 U.S.P. units; vitamin E (dl-alpha-tocopheryl acetate), 5 mg. Tashan Cream is available in 1-oz. tubes.

Reserpine Patent Granted

CIBA, the company which first isolated and introduced reserpine, has been granted a United States patent on the product, embracing crystalline reserpine, its salts, and pharmaceutical preparations of the drug. The company and its affiliates now hold patents on reserpine in many countries throughout the world.

Emil Schlittler, M.D., vice-president and director of research, CIBA Pharmaceutical Products Inc., and Johannes M. Mueller, Ph.D., research chemist at the parent Swiss company, CIBA Limited, Basle, Switzerland, are listed as joint inventors of reserpine in the patent, granted June 26.

For Nausea of Pregnancy

Maredox tablets have been introduced by Burroughs Wellcome for the prevention and treatment of nausea and vomiting of pregnancy.

Each tablet contains 50 mg. "Marezine" brand cyclizine hydrochloride and 50 mg. pyridoxine hydrochloride —the marezine for antiemetic action and the pyridoxine hydrochloride to correct the metabolic disturbance which appears to contribute to nausea and vomiting of pregnancy.

Tablets are supplied in bottles of 25 and 100.

Vaginal Cream

Broxolin Vaginal Cream has been introduced by George A. Breon and Co., for treatment of trichomonal, monilial, and non-specific vaginitis.

Rapid relief of itching, burning and odor was generally achieved in 10 days in clinical studies, according to the manufacturer.

Glyco-biarsol 0.25 gm., containing approximately 15 percent arsenic and 42 percent bismuth, is incorporated into sodium lauryl sulfate, a wetting agent to quickly disperse the medication into mucosal folds. Each 110 cc. tube (three and two-thirds ounces) has an applicator holding 5 cc. of cream.

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clinical notes

New Anticonvulsant

Experiences with a new anticonvulsant N-benzyl-B-cholopropionamide (Hibicon) in 40 patients are reported by Hoenig and associates in *J. Ment. Sc.* 102: 105-111 (January, 1956), London, England.

Twenty-one were outpatients, including 11 with idiopathic epilepsy and major seizures, four with psychomotor epilepsy and demonstrable epileptogenic foci in the temporal lobes, and six with focal epileptogenic areas in other parts of the cortex and with clinical forms other than psychomotor seizures.

The second group all had intractable seizures, and some also had personality disorders.

As a whole, the authors conclude, results were at least as good as with hydantoinates, and were especially encouraging in psychomotor attacks. The drug produced only minor and transitory side-effects.

Menopausal Symptoms

Good or fair results in 91 out of 100 patients who received a synthetic estrogen (Vallestril) for menopausal symptoms is reported by Goldfarb and Napp in the *J.A.M.A.* 161:616 (June 16, 1956).

Of 20 patients who received a placebo, good or fair results were obtained in only 15 percent.

An estrogenic response was evident after 10 to 14 days of medication and persisted for 16 to 30 days after cessation of therapy.

No withdrawal bleeding or other undesirable effects were noted.

Blood-Volume Study

Tissues of men's bodies contain more blood per cubic inch than the tissues of women's bodies, according to Allen and associates, College of Physicians and Surgeons, Columbia University.

Their conclusion is based on results of a study of 55 men and 26 women, made in Formosa and correlated with blood-volume studies of some 700 other individuals in various parts of the world.

The difference amounts on the average to five cupfuls, and has been found to be uniform for various races and ages, Allen writes in the May, 1956 issue of *Clinical and Experimental Metabolism.*

The blood volume of the Formosan subjects was determined by injecting into the veins a nonreactive dye, which gives an accurate measure of volume within minutes by coloring the blood stream.

The studies with which the Formosa results were correlated included 327 cases in which the dye (Evans Blue) was the test substance. The male-female ratio was shown to be uniform, with two exceptions:

(1) The blood volume of young girls is the same as that of boys or men.

(2) The blood volume of pregnant women exceeds that of men by about as much as men's exceeds that of non-pregnant women.

Bioflavonoids Used In Erythroblastosis

Results of treatment of six previously Rh-immunized mothers with water-soluble citrus bioflavonoid compound and ascorbic acid are reported by Jacobs in *Surgery, Gynecology and Obstetrics,* August, 1956.

Three of the patients, who had delivered erythroblastotic babies before, showed no titer rise throughout their pregnancies, and their babies were completely unaffected, the author says.

The other three had a slight rise in titers early in gestation, apparently representing held-over antibody titers from previous immunization, he points out. However, he adds, their babies were healthier and less affected than their previous infants. These infants were given exchange transfusions.

Increased capillary fragility in the baby is a prominent feature of erythroblastosis, the author says, and bioflavonoid therapy helps strengthen abnormally fragile capillaries in the placenta and in the infant.

Moreover, he points out, the antihistamine in the compound may be helpful because Rh-Hr is an antigen-antibody reaction.

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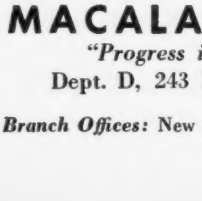

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contributions are welcome

Proper Positioning of Supplies in the Autoclave

By Dorothy W. Errera, R.N.

• The sterilizer operator needs an active imagination and solid grasp of a few fundamentals to load a sterilizer carriage in such a way that all the supplies will be sterilized.

Steam sterilization is a dependable, predictable process —an excellent method of destroying bacteria which demands but a few conditions for effective performance.

Two factors are necessary for sterilization by steam —heat and moisture—and both of these are provided by the steam itself. Steam as it contacts the cold surfaces of a load condenses, and in doing so wets that surface and heats it—much the same way the steam from a boiling kettle will condense on the cold kitchen wall, leaving it wet. The sterilizer operator must make it possible for this process to go on on all surfaces of every article to be sterilized.

Steam destroys bacteria by direct contact only. Successful bacteriologic action depends upon free access of steam to all surfaces in sufficient quantity to heat and moisten. The natural barrier to this process in the sterilizer is air—air in cans, air in tubes, air in the sterilizer.

Air and steam do not mix. Air is heavier than steam and pools in any hollow possible. Clearance of air from the sterilizer is accomplished by gravity through the air and condensate discharge line (see Figure I on page 124). The exit is the small, screened hole located in the bottom front of the sterilizer. The exit is blocked when that screen is full of dirt and bits of rubber bands, paper bags, etc. It should be unscrewed from its position and cleaned at regular and frequent intervals.

Air will also run out from jars, cans, bottles, or other hollow vessels in the sterilizer, provided the means for its escape are provided.

A useful imaginary check for the sterilizer operator is one in which she mentally substitutes water for air. If she can visualize the articles on the sterilizer carriage filled with water and will position them so that the water can only run out, she can be sure that air will also escape. By providing this horizontal path for the escape of air, she makes it possible for steam to contact the inner surfaces of these hollow vessels.

When it is impractical to sterilize a vessel in anything but an upright position, or when air clearance is difficult, as, for instance, from the lumen of a hollow needle or the inside of an Asepto bulb, another feature of steam sterilization can be used to make sterility of that remote surface possible.

This is the fact that when 1 cc. of water is heated to the boiling point, 865 cc. of steam is created (see Figure II on page 125). This information is useful for the operator faced with the problem of sterilizing syringe canisters which cannot be placed on their sides, or flasks which cannot be inverted. One cc. of water left inside that canister or flask will turn to 865 cc. of steam and force the air from that can or flask so that the inner surface is exposed to saturated steam.

Similarly, when suction tubing, Asepto bulbs, catheters, or needles are flushed with distilled water immediately before sterilization, a film of moisture is left which is heated and turned to steam to force air out.

Why distilled water?

Because tap water in most localities is hard—that is, it contains mineral salts which accumulate as a dry crusty layer.

These are examples of steam exerting a surface effect —contacting a cold surface, condensing, wetting, and heating.

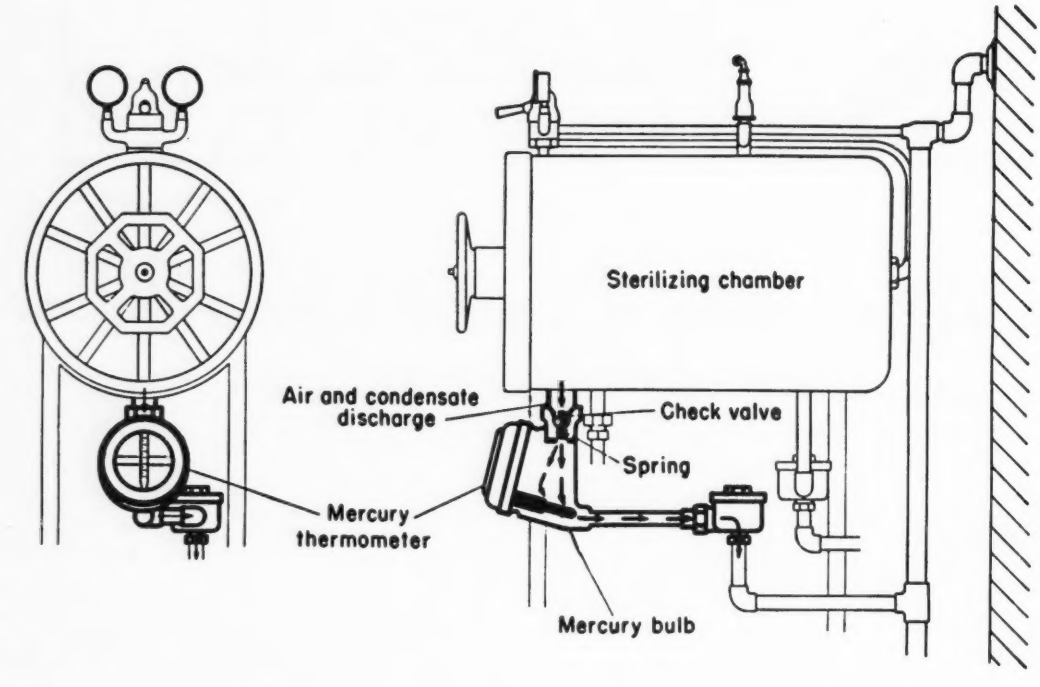
This same action goes on when steam must penetrate a porous object to reach its contents. It heats and wets from the outer permeable surface through to the center. What steam will penetrate may well be answered by the question—what will water soak through? If water will run through a material, it is reasonable to say that steam will also get through at a rate sufficient to sterilize the contents.

The sterilizer operator can evaluate her sterilizing wrappers by simply making a sack of one, filling it with water, and watching the rate with which the water soaks

(continued on next page)

Illustrations for this article are from **Aseptic Treatment of Wounds** by C. W. Walter, M.D.: The MacMillan Co., 1948.

THERMOMETRIC CONTROL OF STERILIZATION



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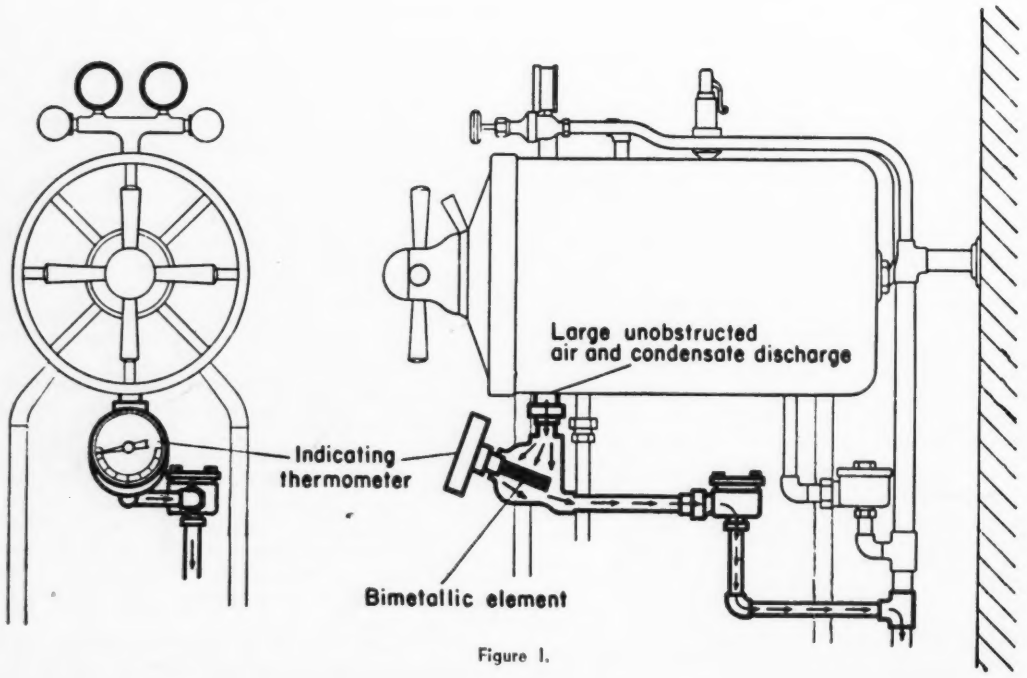
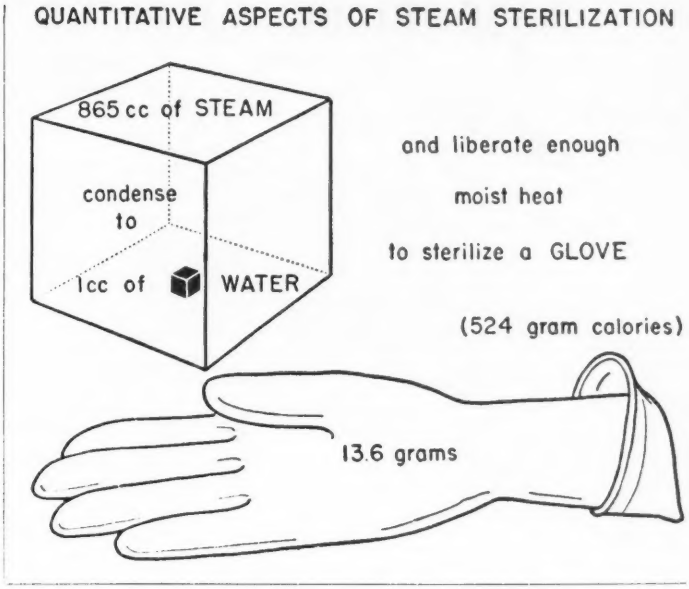


Figure I.

Figure II.



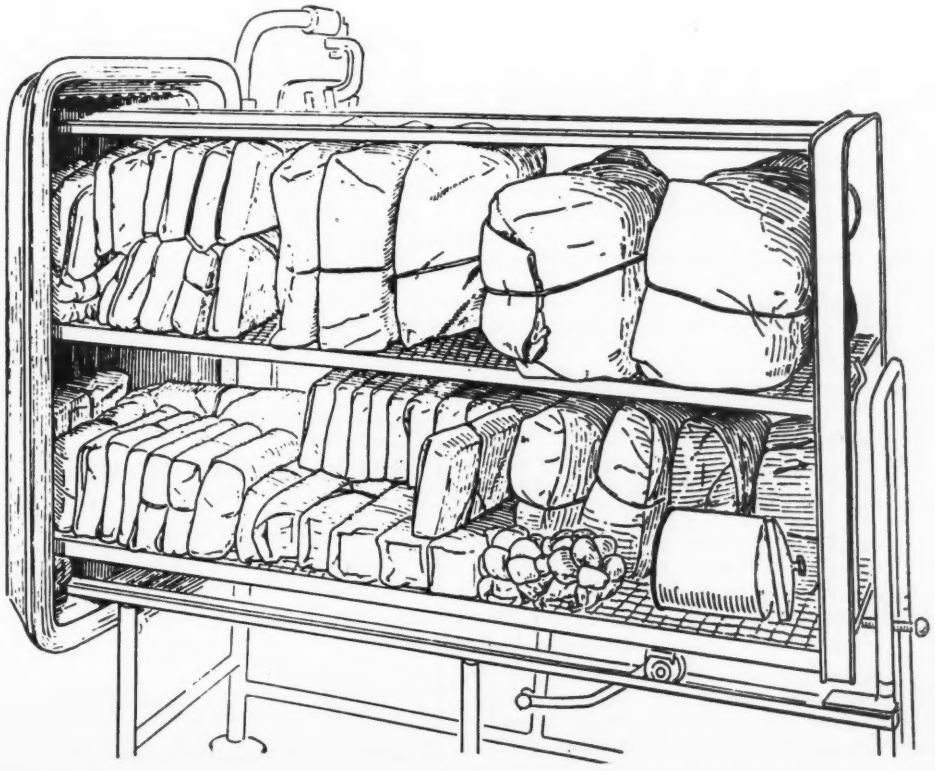
CENTRAL SUPPLY Continued

through. It must not only be permeable—that is, let steam pass through—but must be enough so that penetration is accomplished in the time allotted for the sterilizing cycle. Water-proof paper, water-proof duck, and other materials made to keep water out will most certainly not let steam in rapidly enough to be effective.

Even with permeable wrappers and proper positioning of supplies, sterilization can be frustrated by loading—that is, literally LOADING a sterilizer carriage! Carriages so densely packed that force is needed to close the sterilizer door deliver unsterile supplies. Supplies

(Continued on next page)

Figure III.



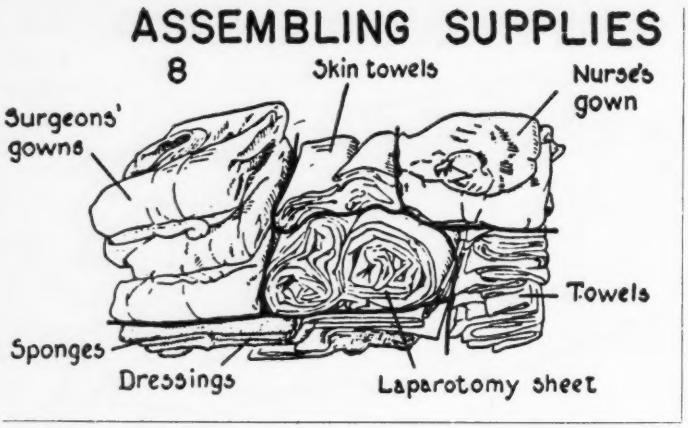


Figure IV.

CENTRAL SUPPLY Continued

packed under the weight of the load are tightly compressed, trap air, choke channels of penetration, and escape contact with steam. An open-shelved sterilizer carriage (see Figure III on previous page) guards against overloading, because tight packing is impossible—inasmuch as anything that is not free-standing simply falls off.

Large packs of dry goods are problems in penetration and heating. The size should be limited to that which has been studied for heating and penetration times. The contents should be arranged loosely and in such a way that the kit is actually several small kits. This makes for quicker heating and penetration.

A large, heavy laparotomy sheet, loosely rolled and placed in the center of the pack as two upright cylinders, provides a port of entry for steam flowing into the various segments of the kit (see Figure IV). On the other hand, the same large, heavy laparotomy sheet folded into a rock-like handkerchief is difficult to penetrate and effectively blocks steam on its way through the kit.

The sterilizer operator should survey the sterilizer load critically with these few facts in mind. She should picture the possibilities for free exchange of air and steam, imagine steam contacting all surfaces to be sterilized, and position dressing cans, suture jars, test tubes, etc. on their sides with lids removed. It makes no difference whether they are oriented to the back, front, or side of the sterilizer—the concern is for that horizontal path for the escape of air.

Tightly nested basins should be repacked, separated by a towel or sponge so that steam can reach all surfaces. Instruments should be sterilized unlatched—not in an untidy, unwieldy, tangled mess, but merely unlocked and arranged on instrument hooks so that steam can reach the remotest part of boxes and catches.

Rubber gloves challenge attention to detail. In the sterilizer, there is only one position in which they can be sterilized—that is, horizontally with the thumbs uppermost. Any modification creates conditions for incomplete sterilization.

If they are sterilized in piles, the bottom packages are compressed and escape contact with steam; if they are sterilized in a vertical position with the fingers down, the whole gloves trap air which can never run out.

If they are sterilized in a vertical position with the fingers up, the inner surfaces are exposed to dry heat, which requires a longer time for sterilization. As steam enters the sterilizer, it contacts the outer surface of the glove first and heats and wets it. By the time steam seeps into the glove, it meets a heated surface and cannot condense.

In Figure V, the fish tank represents a steam sterilizer. The water filling the tank represents air in the sterilizer. When the cork is removed from the discharge line, the water runs out. It obviously pools forever in the upright dressing can and capped flask; it clears but only tardily from the inverted suture jar and dressing drum (represented by the petri dish with holes placed to simulate the openings in a dressing drum). It runs out quickly from the can positioned on its side, uncovered.

Steam will destroy all bacterial life in 15 minutes at 250° F. It will do so consistently, efficiently and economically if given the opportunity to reach all the material it is expected to sterilize. This simple need is provided by:

(1) Proper positioning to allow for an escape of air

(2) Avoiding tightly fitting surfaces

(3) Using permeable wrappers

(4) Avoiding overloading and dense packing of the sterilizer

(5) Providing the moisture necessary to create steam in those situations in which penetration or gravity clearance is impossible.

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Volume I.

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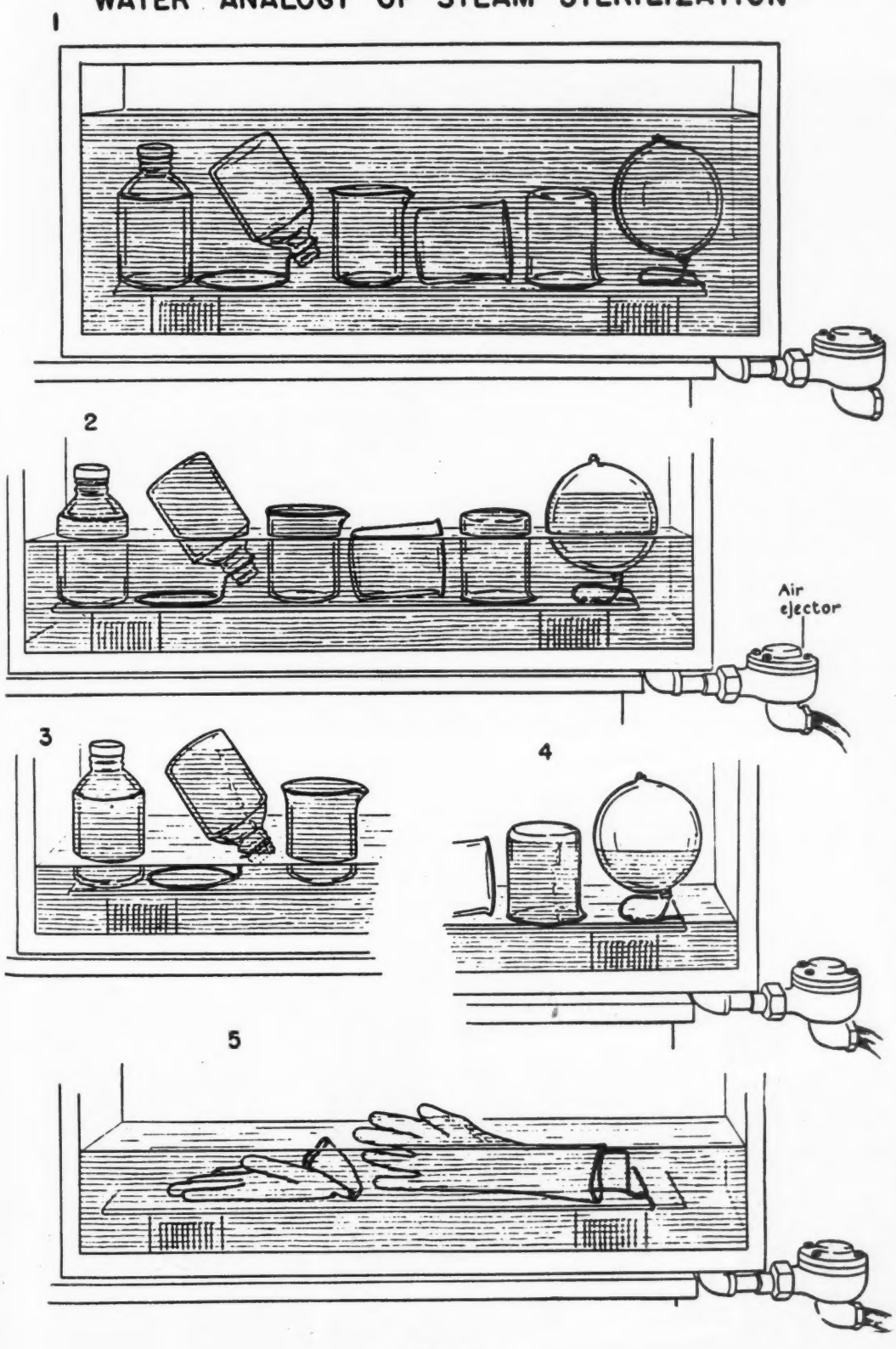

Figure V.

Ease pain with

Nupercainal®

long-acting surface anesthetic

From abrasions to anal fissures, from simple burns to hemorrhoids to herpes zoster—from A to Z—Nupercainal belongs in the hospital routine.

For it provides prompt, lasting relief from pain and itching. Considered as probably "the most potent local anesthetic currently available,"[1] Nupercainal has a low sensitizing index.

OINTMENT, 1% Nupercaine® (dibucaine CIBA) in lanolin and petrolatum base.

CREAM, 0.5% Nupercaine in water-soluble base.

OPHTHALMIC OINTMENT, 0.5% Nupercaine in white petrolatum, with applicator-tip tubes.

1. Drill, V. A.: *Pharmacology in Medicine*, McGraw-Hill Book Company, Inc., New York, 1954, p. 9/11.

NUPERCAINAL® Ointment (dibucaine ointment CIBA)
NUPERCAINAL® Cream (dibucaine cream CIBA)

CIBA
SUMMIT, N. J.

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(No. 80-61 SEMI-PRIVATE ROOM)

A New Hill-Rom Semi-Private Room Grouping

(Series 8,000—color styled by Howard Ketcham)

Hill-Rom
Contemporary
FURNITURE FOR THE MODERN HOSPITAL

● Shown above is a semi-private room grouping of the new Hill-Rom 8,000 series. The attractive color scheme (Du Pont Cherry) is one of many richly varied effects suggested by Howard Ketcham, noted color expert. These color schemes make it easy to visualize many different possibilities for private and semi-private rooms, and to make patient rooms and units truly inviting.

Included in the above grouping are: No. 80-61 Manual Hilow Beds, No. 8003 Bedside Cabinet, No. 80-614 Overbed Tables, No. 8025 Straight Chairs, No. 8008 Arm Chair, No. 8026 Chest Desk, No. 305 Lamp and No. 300 Safety Sides. (The No. 80-62 Motor Hilow Bed is also available with this grouping). All posts and framework are of solid maple. The panel work is cherry wood. Tops of the chest desk, overbed table and bedside cabinet are high pressure laminate, cherry grained, heat and stain resistant.

Write or wire for further information on this grouping.

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Perfected Screening
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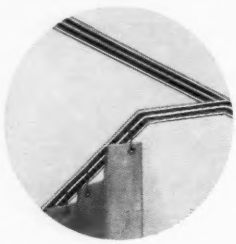
- **Ease of Installation**
- **Smooth, Quiet Operation**
- **Minimum Maintenance Worries**

The machined nylon rollers used in Hill-Rom Perfected Screening glide easily and noiselessly on the I-beam track. The exclusive Hill-Rom two-stage corner doubles the effective radius and minimizes binding action around corner bends.

Hill-Rom offers two distinct types of Perfected Screening—Near-Ceiling, for suspended installations, and Recessed-in-Ceiling, designed primarily for built-in installations in new construction. Both of these types employ the same channel, track, fixtures and curtains, and give the same quiet, easy operation. Both types are furnished in standard units (another exclusive Hill-Rom feature) to permit proper screening of rooms of all sizes and shapes.



Close-up of the exclusive Hill-Rom Two-Stage Corner

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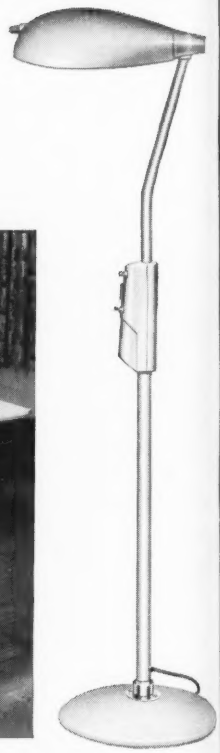
The right light... from any angle
direct... indirect... inverted!



with the NEW Hill-Rom No. 306 Floor Lamp
(designed by Raymond Loewy)

• Here is a lamp that provides a perfect reading light, whether used at the bedside or beside an arm chair. A lamp that gives the doctor an unsurpassed light for examination, whether in the patient's room or in the doctor's own offices. A lamp that is equally serviceable in the library, solarium, television room or other public room. A lamp that can be easily adjusted for indirect lighting (with shade inverted) or for minimum light (night light). Also the light may be directed away, easily and quickly, through use of the "swivel-in-base", when the patient tires of reading.

With all of these conveniences and advantages, this new HILL-ROM lamp is completely safe—listed by Underwriters' Laboratories. The shade can be rotated in a complete arc without twisting, or even moving, the wires. The convenience outlet is safe for any appliance. All control switches are within easy reach of the patient.

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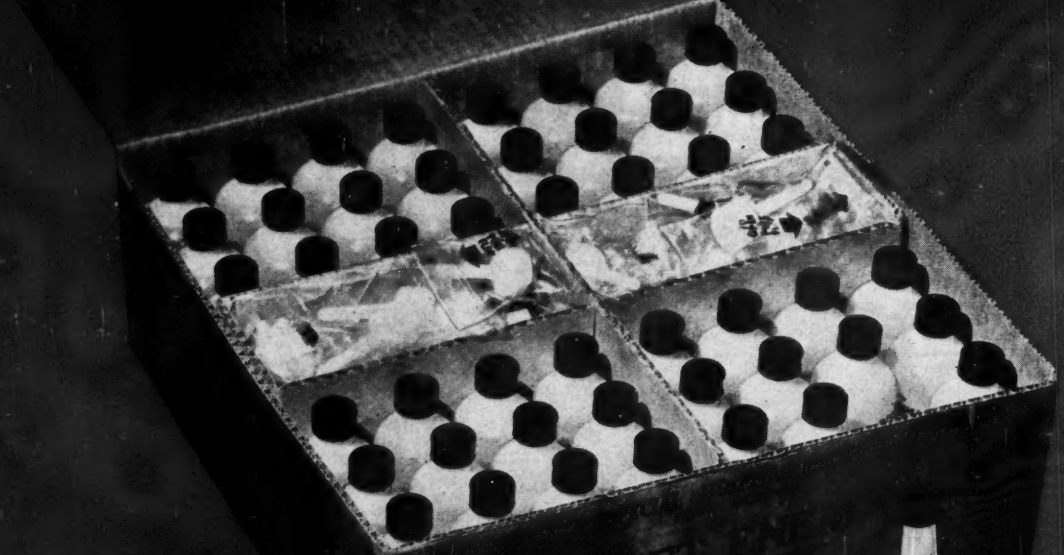

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30 5/8 ¢	24 doz.
30 ¢	48 doz.

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Albert Hahn Reappointed State Council Member

Albert G. Hahn, administrator, Protestant Deaconess Hospital, Evansville, Ind., has been re-appointed by Gov. George Craig to a four-year term as member, Hospital Licensing and Regulating Council, Indiana State Board of Health.

The council has aided hospitals in promoting improved standards for patient care.

Assign Army Nurses, Dietitian To Administration Course

Three Army Nurse Corps officers and a dietetic officer from Army Medical Specialist Corps are among 50 officers assigned to the Army's most advanced course in hospital administration.

The nine-month course, beginning this month, is given at the Army Medical Service School, Fort Sam Houston, Tex. Graduates will be eligible for an M.A. degree from Baylor University, Waco, Tex., with which the course is affiliated.

The nurse officers are: Maj. Mary L. Burrows, Williamsport, Pa.; Maj. Alice E. Weinstein, Burlington, Vt.; and Maj. Ann E. Hogan, Waterbury, Conn. Capt. Cecilia T. Klainer, New York City, is the Army dietitian.

Bureau of Standards Plans Relocation

A tract of approximately 550 acres near Gaithersburg, Md., has been selected for relocation of the Washington laboratories, National Bureau of Standards.

Transfer of operations, which is expected to be completed in about five years, will permit planning of new buildings to replace present research facilities.

Journalism Fellowship Open To Graduate Nurses

Applications from graduate nurses for the 1957 Mary M. Roberts Fellowship in journalism are now being accepted by the American Journal of Nursing Company's Fellowship Committee.

Recipient of the fellowship will be granted $3,000, besides tuition fees, for an academic year's study in journalism at a recognized college or university.

Application forms and complete details of the competition may be obtained from Roberts Fellowship Committee, American Journal of Nursing Co., 2 Park Ave., New York 16.

The competition closes February 1, 1957.

Dr. Zollinger Named Head Of VA Medical Group

Robert M. Zollinger, M.D., professor and chairman, department of surgery, Ohio State University, has been elected chairman, VA Special Medical Advisory Group.

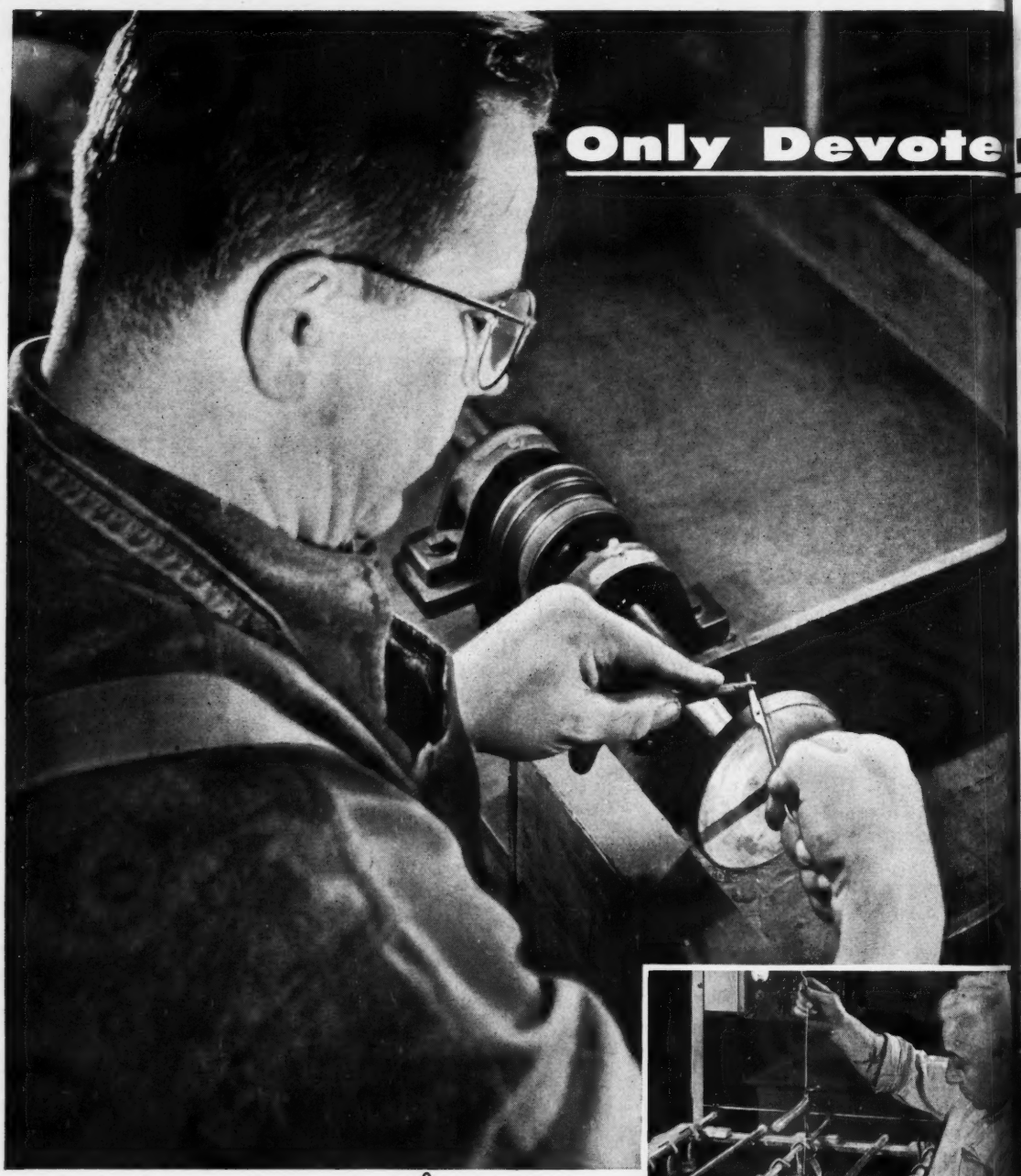
Dr. Zollinger, vice-chairman of the group for two years, succeeds Wendell G. Scott, M.D., professor of radiology, Washington University, St. Louis.

George E. Armstrong, M.D., director and vice-chancellor, New York University-Bellevue Medical Center, New York City, was elected new vice-chairman.

Hospital Patient Statistics Show Increase in 1955

U. S. hospitals cared for 21,072,521 patients in 1955, more than in any previous year, according to the AHA. This was an increase of 727,090 over 1954's total, 20,345,431.

Hospital births last year totaled 3,476,753, a rise of 134,154 over 1954's 3,342,599.



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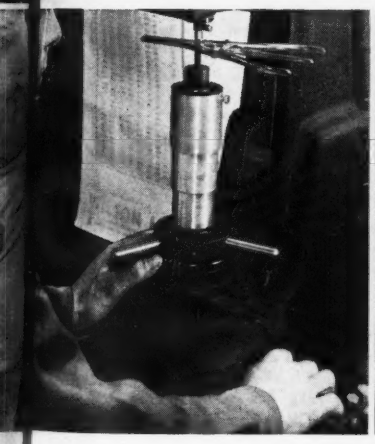
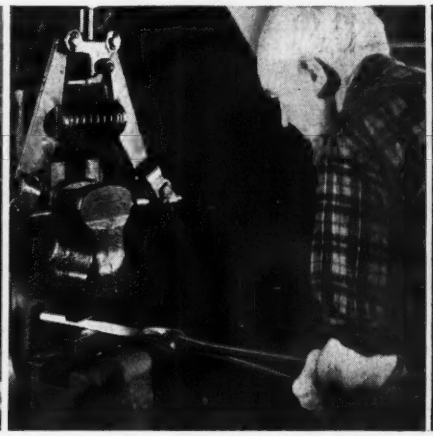
Whether you require new instruments or repair service, delivery is fast, sure and dependable. American can provide these premium services without a premium in time or cost, so ask your American Hospital representative for details.





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(Continued from page 117)

resume of the true facts and a request to join in finding a solution. We do a lot of talking and remain a party to the crime by accepting conditions and failing to take action.

All of these things convince me that operating room nurses have a definite responsibility in taking interest particularly in our schools of nursing. Can it be proved that operating room experience is of no value to the student? Is it wise to rush her through six weeks in the operating room when she is young and immature, frightened not from the autocratic supervisor but from the confusion caused by a shortage of professional nurses?

Let us lose no time. Conditions are getting worse by the day. Let us work to develop operating room staffs that speak of job satisfaction and gratifying experiences. Our hope lies in the student and young graduate nurse, but it takes work and cooperation to develop programs to adequately prepare them.

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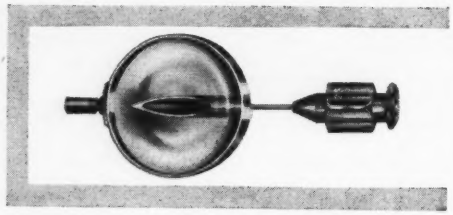

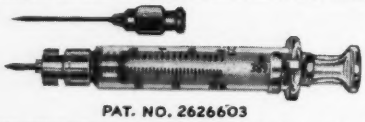

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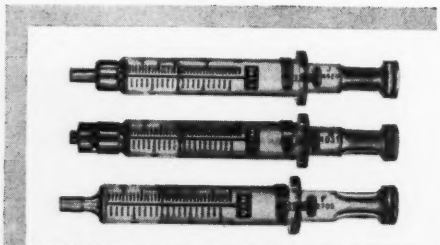

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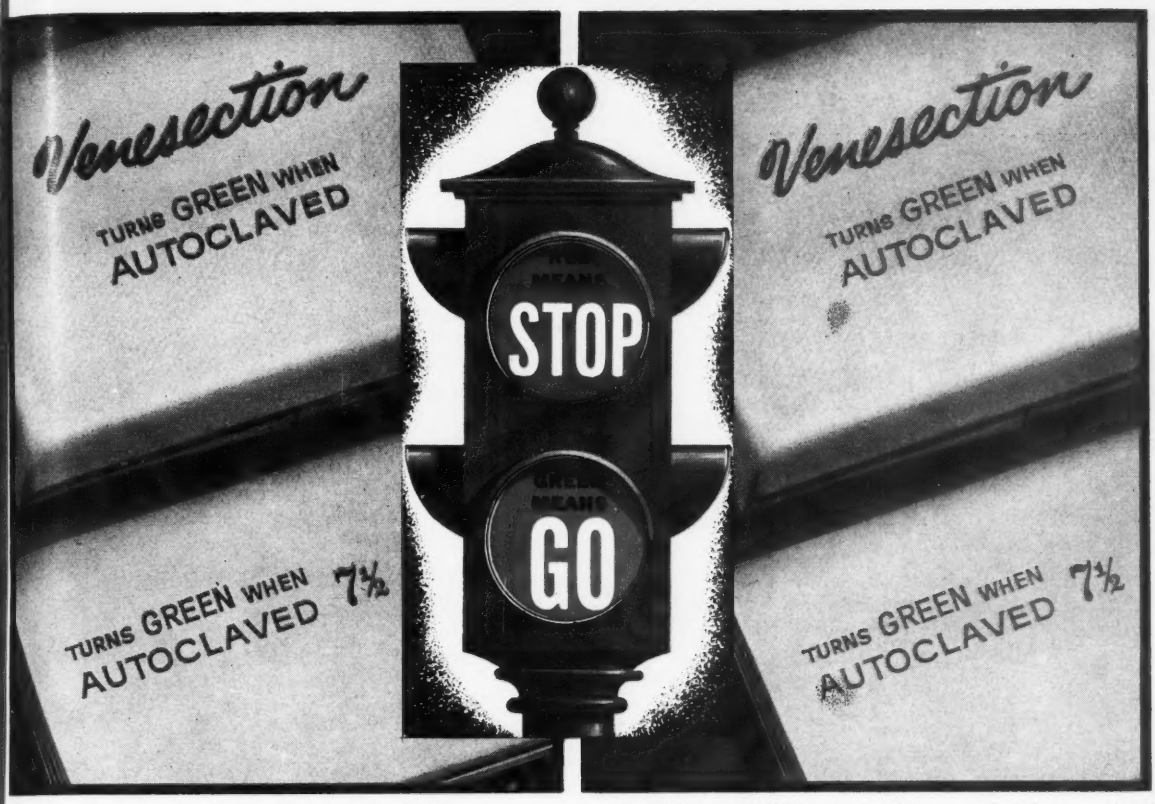

The ink in the handwriting and stamped lettering is RED

The ink has turned GREEN indicating that contents have been autoclaved

Introducing

WECK AUTOCLAVE INK

– turns GREEN when autoclaved

Here is a simple and inexpensive method of identifying packs, trays and miscellaneous articles that have been autoclaved*. When the ink is applied it is RED – when autoclaved it is GREEN!

Everybody knows the colors of traffic lights – no chance of making a mistake under the stop-and-go control of Weck Autoclave Ink.

The ink may be applied in either of two ways: 1 – with Weck Autoclave Pencil containing leads of Weck Autoclave Ink in compressed form; 2 – with stamp and special stamp pad of foam rubber (felt pads can not be used).

Each Weck Autoclave Ink Set, as illustrated, contains a combination rubber stamp with this wording on one side "TURNS GREEN WHEN AUTOCLAVED" and an adjustable unit on the other. The latter provides almost any combination of letters and numbers for identifying contents of packages. Any type of stamp may be made to fit a hospital's special needs. Also available are individual adjustable stamps; as well as individual "TURNS GREEN WHEN AUTOCLAVED" stamps which are for use with the Weck Autoclave Pencil alone.

*Autoclaving is not, per se, proof of sterility.

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	Each	Doz.
Weck Autoclave Ink—2 oz. dropper bottle	$ 6.50	$ 65.00
Weck Autoclave Stamp Pad	.75	7.50
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Total	$23.50	$235.00
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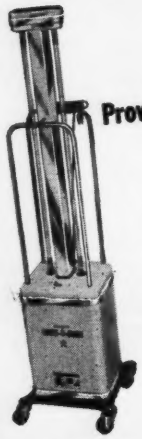

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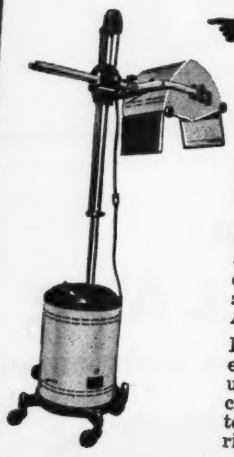
Less than one hour irradiation more effective than usual 24 hour airing. Achieve prompt reuse of contaminated areas with Hanovia's Portable Room Air Sterilizer. In just 30 minutes of irradiation following clean-up procedures, Hanovia's Portable Safe-T-Aire Sterilizer disinfects the average vacated two-bed room making it available for immediate reoccupancy. Wheels quickly, easily from room-to-room on noiseless casters. Hospital administrators appreciate the value of this practical unit as a final precaution in the clean-up of operating rooms, children's clinics, isolation, autopsy, cystoscopy and emergency rooms and laboratories.



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Delivers complete ultraviolet spectrum required for general therapeutic use. Starts instantly at snap of switch, provides intense radiation and an even distribution over a wide, shadowless surface.

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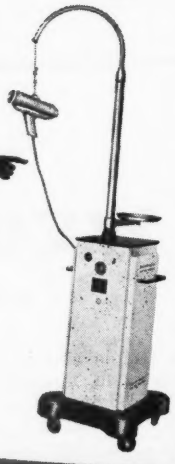
Intense, concentrated source of ultraviolet for local and orifical application. Provides accurate control of clinical actinic reaction on skin surfaces or within the body cavities. Air cooled!

In hospitals, in offices, Hanovia equipment is proving the value of ultraviolet in the treatment of many conditions. Of proven value in internal medicine, pediatrics, obstetrics, dermatology, and orthopedics.

H



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Wide Range of Hanovia Ultraviolet Applications Include:

Surgery: Sluggish wounds that do not heal or are abnormally slow in healing may respond favorably to local or general irradiation.

Tuberculosis: Irradiation is of distinct value in treatment of tuberculosis of the bones, articulations, peritoneum, intestine, larynx, and lymph nodes.

Skin Diseases: Hanovia ultraviolet radiation acts specifically on lupus vulgaris, has a beneficial effect in such conditions as acne vulgaris, psoriasis, pityriasis rosea, indolent ulcers and some forms of eczema.

YOURS ON REQUEST: Valuable brochure detailing use and benefits of Hanovia Portable Safe-T-Aire Units. Also available, authoritative treatises describing Ultraviolet in Eye, Ear, Nose and Throat Conditions; in Skin Conditions; in Pediatrics; in Diagnosis; in General Practice. Without obligation, write for your free brochures today. Dept. HT-9

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